SUPPLEMENT No. 3 TO THE
INTERNATIONAL JOURNAL OF PSYCHO-ANALYSIS

THE TECHNIQUE OF PSYCHO-ANALYSIS

By

EDWARD GLOVER, M.D.

Assistant Director, London Clinic of Psycho-Analysis

THE INTERNATIONAL JOURNAL OF PSYCHO-ANALYSIS

EDITED BY

ERNEST JONES

WITH THE ASSISTANCE OF

G. BOSE, CALCUTTA
A. A. BRILL, NEW YORK
D. BRYAN, LONDON
J. VAN EMDEN, THE HAGUE
S. FERENCZI, BUDAPEST
J. C. FLÜGEL, LONDON
E. OBERHOLZER, ZÜRICH
C. P. OBERNDORF, NEW YORK
E. SIMMEL, BERLIN
ADOLPH STERN, NEW YORK
M. WULFF, MOSCOW

Published for the Institute of Psycho-Analysis
BY BAILLIÈRE, TINDALL & COX, 7 AND 8 HENRIETTA STREET,
LONDON, W.C. 2
1928

Price Six Shillings net

Recently Published

THE FUTURE OF AN ILLUSION

by

SIGMUND FREUD, M.D., LL.D.

IT is becoming increasingly recognised that Professor Freud is one of the most profound students of human nature. His opinions on the main topics of human interest must, therefore, possess great value. In this new volume he deals with what is perhaps the vastest of all problems, that of religion, and also ventures predictions about the future of religious belief. He regards religion as one of the most important factors in the development of civilisation, but considers that the form it assumes must constantly undergo evolution.

Published for the Institute of Psycho-Analysis

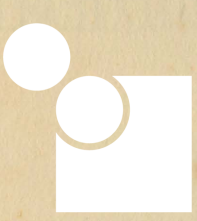
BY

THE HOGARTH PRESS

52, TAVISTOCK SQUARE

W.C. 1

Price Six Shillings net



INTERNATIONAL
PSYCHOANALYTIC
UNIVERSITY BERLIN

SUPPLEMENT No. 3 TO THE
INTERNATIONAL JOURNAL OF PSYCHO-ANALYSIS

THE TECHNIQUE OF PSYCHO-ANALYSIS

By

EDWARD GLOVER, M.D.

Assistant Director, London Clinic of Psycho-Analysis

THE INTERNATIONAL JOURNAL OF PSYCHO-ANALYSIS

EDITED BY

ERNEST JONES

WITH THE ASSISTANCE OF

G. BOSE, CALCUTTA
A. A. BRILL, NEW YORK
D. BRYAN, LONDON
J. VAN EMDEN, THE HAGUE
S. FERENCZI, BUDAPEST
J. C. FLÜGEL, LONDON
E. OBERHOLZER, ZÜRICH
C. P. OBERNDORF, NEW YORK
E. SIMMEL, BERLIN
ADOLPH STERN, NEW YORK
M. WULFF, MOSCOW

Published for the Institute of Psycho-Analysis
BY BAILLIÈRE, TINDALL & COX, 7 AND 8 HENRIETTA STREET,
LONDON, W.C. 2
1928

PRINTED IN GREAT BRITAIN BY THE WHITEFRIARS PRESS, LTD., LONDON AND TONBRIDGE.

EDITORIAL PREFACE

THESE lectures, delivered in the spring of 1927 as part of the training course of the Institute of Psycho-Analysis, represent, in my opinion, the most comprehensive and one of the most original contributions to the difficult problem of technique in psycho-analysis that have ever been made. It is a theme that most analysts are chary to embark on, and Dr. Glover is to be congratulated on the courage with which he unflinchingly faces all the complicated problems connected with it. By not making his presentation too simple he has also ensured that only those will benefit from it who devote attentive study to what he has to say. There are not many books absolutely indispensable to the practising analyst, but this is assuredly one of them.

E. J.

August, 1928.

TABLE OF CONTENTS

THE TECHNIQUE OF PSYCHO-ANALYSIS

THE TECHNIQUE OF PSYCHO-ANALYSIS

BY

EDWARD GLOVER

LONDON

I

INTRODUCTION: THE ANALYTIC SITUATION

The difficulties of psycho-analytic technique are conveniently resolved into two groups, those incident to the patient and those incident to the analyst, or in other words, the difficulties inherent in the case-material and those inherent in the method of investigation. Of these, the analyst's own difficulties are the more important, because they influence not only his own attitudes and reactions but colour his view of the *patient's* condition and reactions. At the outset, therefore, we have to come to a definite decision about policy: are we to assume as the basis of our study a hypothetical 'perfectly analysed' individual making analytic contact with a neurosis of classical outline, or may we take it that the analyst is an ordinary individual who has, through his own analysis, been freed from the main sources of unconscious bias, and is now approaching the routine of ordinary analytic practice where mixed cases of every conceivable sort constitute the greater part of clinical material? The question might be put in another form; should we commence with a discussion of phenomena such as transference, resistance, etc., exhibited by the patient or with a discussion of the phenomena of counter-transference, counter-resistance, liable to be exhibited by the analyst?

In actual fact it will be necessary to combine both plans, and in

dealing with the *material* presented in analysis to assume that the analyst has been completely freed from all sources of unconscious bias, while in considering the *handling* of this material to assume that the analyst might be influenced by subjective tendencies. To avoid confusion, I propose to indicate on each occasion which of these standpoints is adopted. On the present occasion I intend to consider first of all the general attitude and reaction of the analyst on deciding to start his first case, but before he has actually compassed the first interview. Before doing so I think it is worth while to go back and consider the significance of the term ' perfectly analysed analyst ' : one who is hypothetically ready to cope with any situation and for whom lectures on technique would be superfluous. When we come to consider later the innumerable derivatives from the castration complex, it will be apparent that this somewhat heroic figure may conceivably spring from unresolved elements in this group of reactions, representing, on the one hand, the all-powerful parent who knows everything and does no wrong or ought not to do any, who is perfect and potent, and on the other the dependent child who has renounced his forbidden longings, i.e. is ' perfectly analysed ', pure by virtue of castration. It is a doubly ambivalent attitude and is reflected at one time or other in the ideas and attitudes of every patient. Regarded theoretically, it is a legacy from those earlier days when the conception of the ego was limited, and repressed complexes were vaguely regarded as the sole content of the system Ucs. Freud's distinction of an id system, a reservoir of instinct-tendencies, cleared the ground in this as in innumerable other respects. The repressed is included in this system but is very sharply separated from the ego, whereas the id is not so sharply separated. Successful analysis, then, will have uncovered the repressed ; if it has done so it will by the same token have mitigated the archaic censoring functions of the super-ego, but it can scarcely be expected to abolish the id. In other words, the id is always with us, and the most thoroughly analysed analyst has, like everyone else, to see that his newly-won freedom from automatic archaic control of instinct-excitation does not tend to be weakened from time to time by recourse to easier but ill-adapted methods of ' defence '.

Two other considerations are relevant here. A training analysis is in no way different from a therapeutic analysis ; hence it is scarcely possible, even if it were desirable, for the prospective analyst to have much objective grip of the various libido-movements and ego-alterations occurring during his own analysis. In the next place, even if he did

have this grip, it is not to be concluded that the conduct of his own analysis would necessarily be a serviceable model on which to standardize *all* his subsequent analyses. This is not the place to discuss processes of sublimation, but it is at any rate beyond dispute that some people are stimulated to develop an interest in psycho-analysis to some extent by their own experiences of mental conflict. In such cases the position is clear ; they will fall roughly into some grouping—hysterical, obsessional, depressive, etc.—and will be treated accordingly, so that their most objective view of their own analysis will be that of an analysis appropriate for their particular type. But in fact this is also true of the alleged normal, who usually shews characteristics which are at least reminiscent of the more symptomatic groupings. An obsessional type, for instance, with his devious mechanisms for dealing with affect, is not so likely to have immediate instinctive appreciation of the affective urgencies of an hysterical type ; and the hysterical type would be more inclined to see little point in the roundabout technique of the obsessional. So that even were there no unconscious significance underlying the concept of the ' perfectly analysed analyst ', it is more than questionable if this qualification would exempt anyone from the necessity of technical training.

We need not go further into this for the moment, since the matter will be considered more fully under the heading of counter-resistance, but I think there is some advantage to be obtained from approaching our problem unshackled by the products of omnipotence and inferiority phantasies. We have every right to insist that a prospective analyst should be in touch with his own unconscious tendencies, so that when the occasion arises he will have no axes to grind in the analytic situation, and we may be certain that, if this has been attained, his analysis will have been comparatively thorough.

We are assuming, however, that he has not yet tested his powers by the analysis of an actual case, and some further reassurance may not come amiss. I have the impression that many approach their first case with something of the trepidation which accompanies the young surgeon to his first abdominal operation ; and, if I may pursue this comparison without prejudice, the rational elements in this attitude have much the same basis in both instances. The budding surgeon fortifies himself overnight by careful study of surgical anatomy, only to find that his anticipated difficulties do not materialize, whereas numerous unexpected bewilderments appear from nowhere. In the same way the analyst has gathered from his theoretical reading many so far

uncharted apprehensions about complicated analytic situations ; and when these do not appear to materialize immediately may on the rebound proceed cheerfully enough, until he is faced with such a perplexing situation as the heaping up of negative transference. Leaving out of account unconscious motivations, we may say that this wavering judgement and reaction is partly due to the somewhat intimidating nature of the literature on the subject. He has been warned so much, for example, about the ' handling of the transference ' that he may be forgiven for a certain tendency to handle it at inappropriate moments, or to be unduly gingerly in touch at points where free handling is essential.

To continue this line of thought : perhaps one of the greatest difficulties to overcome in early work is what we might call a too ' anatomical ' view of the analytic process : it is a commonplace that a good anatomist is not necessarily a capable surgeon. Here again the stereotyped form of systematic expositions of psycho-analysis is partly responsible for the attitude. It is inevitable that in describing unconscious processes different chapters should be devoted to ' slips ', ' forgetting ', ' dreams ', ' interpretations', ' resistance ' and so forth ; but the analysis of a slip, for example, as it were isolated from the text, is mostly an interesting experience for the analyst. I do not mean to suggest that the analysis of slips is ever to be underrated. On the contrary, it is one of the most valuable and legitimate exercises in analytic technique, to which constant resort will be made. But I do suggest in this particular connection that an ' anatomical ' tendency to hail it with joy and, irrespective of its connections, to nuzzle it on the mat, as it were, smacks more of the analytical connoisseur than the analytic strategist. To give additional point to this, I would remark that there are occasions when a slip has to be treasured for future reference, and in cases of serious ego-disorder it may function as a danger-signal. A suicidal patient I am treating at present frequently confounds the words ' wife ' and ' sister ', but I am not at all happy when the number of these slips increases. When, as very rarely occurs, their form is altered to imply a wife-mother equation, I am not surprised should he take an early opportunity of expressing consciously great hate of his mother, have more restless nights and exhibit renewed interest in knives and razors. To return to slips, the method of seizing upon these as if they were indiscretions on the part of the patient is, I imagine, due to a tendency to regard analysis as an assortment of reactions on the patient's part somehow assembled together and

capable of detection like the constituents of a mixed salt in a ' practical chemistry ' examination. The same tendency reaches its acme of futile isolation when amateur ' analysts ' make social capital of the slips of their friends, usually driving the matter home against the grain, with the remark ' Oh, we know what that means'.

I have made use of the slip to illustrate an attitude towards analytic manifestations, but the same can be said of other material, e.g. dreams. It is true that where dream-material exists the analysis of these dreams is an all-important and essential part of our technique, and there are innumerable occasions when in spite of the patient's lack of interest in the matter it is necessary to seize on some fragment or other and subject it to detailed analysis. But in no case should the dream be taken apart from the context as if it were a tonsil capable of enucleation and subsequent dissection. Again, it is true that many dream-fragments can be very exhaustively analysed, but most attempts to aim at this thorough handling of *every* dream irrespective of the state of the analysis are liable to end in disappointment, and—what is more —will ultimately be turned to advantage as a resistance by patients who are prepared to deliver a postal packet of dreams at the beginning of each session, as if to say ' Now go ahead, my job is finished for the day '.

If we may look for more fundamental explanations of this ' anatomical ' attitude, it will be found to relate to some reluctance to appreciate the defensive functions of one's own mental apparatus, a difficulty in regarding the mind as a functioning instrument or organ. To take a further illustration, we may consider two ways of regarding any of the silent pauses which from time to time break the thread of analytic association. From the descriptive standpoint the silence may be regarded as a kind of artifact or flaw disturbing an experimental situation, a significant flaw, it is true, but somehow something *wrong with* the associations. If now we take the dynamic standpoint, it seems to me we have a much more vivid comprehension of the situation. What we have done in applying the association rule is to attempt to free an apparatus from certain inhibiting mechanisms, i.e. from secondary processes ; we are allowing the powerful drives and affective charges of the unconscious system to operate in as unhampered a way as possible during waking hours. A selective process is immediately set to work, and as soon as we who are listening have recognized the main theme we can follow it quite simply up to the point where the unconscious presentation comes too near the surface for the patient's ego : then comes the pause.

On a less wary day the train of thought might have ended in a sudden slip giving the keynote of the theme or at another time the unconscious theme of the association would be seen openly illustrated in some fragment of a reported dream. We have in fact been watching the operation of the pleasure principle, first, in so far as the id system has been given an opportunity of gaining open expression and, secondly, in so far as the ego has reacted to too open expression through one of its modes of defence, the evidence for which is the recurrence of a pause. Now, in the case of the suicidal patient I have described, the slips he produced could not be seized on immediately and analysed, for the reason that his ego had already shown signs of relative helplessness in dealing with id-excitations and, on the other hand, was obviously at the mercy of a strict super-ego. It seems to me that in such circumstances energies can for the moment be more advantageously directed, somewhat arbitrarily if need be, towards the analysis of whatever guilt-signals appear during the session. For purely practical reasons then my policy was to leave the slip and attack the punishing system. Of course this is an extreme case, not to be made the basis of a general rule, but in a sense the same sort of attitude is necessary in ordinary everyday analysis. Interpretation of unconscious phantasy material must as a rule be timed to take effect when the defensive systems (the primitive ego attitudes) have been really weakened.

Coming back once more to the attitude of the analyst, the first prerequisite of effective analysis is some comprehension of the structural organization of the mind, its function as a whole organ, the continuity of the function and the rough appropriateness of its methods of defence. The next is some appreciation of the fact that in any psycho-analysis we are not approaching this actively operating mental structure as the pathologist approaches the post-mortem platter, or as the biochemist conducts experiments *in vitro*. Nor indeed can we say that we are about to study this mental organ in the way that the cardiologist watches a heart in a state of auricular flutter, or a radiologist follows the course of a bismuth meal. We are about to initiate the development of a special situation, to regulate its course and bring it to a termination. Our main generalization is, then, that a *process of psycho-analysis is essentially a situation which develops along the same general lines in all cases but has individual form.*

But we cannot escape altogether the descriptive method of regarding this situation, so we may go on at once to say that *it is a situation capable of loose division into theoretical stages.* Each of these statements

is a necessary check on the other, since tendencies exist either to regard analysis as a form of therapeutic *interference* for which the analyst is mostly responsible, or on the other hand to see it as a rigid phenomenon with cut-and-dried stages which must be gone through according to plan, as it were an obstetrical situation with the analyst as midwife. Both of these points of view arose naturally during the development of psycho-analytic technique. The early cathartic phase and a good deal of the period of complex-hunting and interpretation accord simply with the view of therapeutic *interference from without.* Closer study of transference-manifestations, including the phenomena of repetition and re-enactment of memories, working through, etc., brought with it a clearer idea of the 'transference-neurosis', by which is meant the re-staging of the neurotic conflict in analysis and in relation to the analyst. By this time the idea of an analytic 'situation' had developed, and concurrently our views of ego-structure were greatly, expanded by Freud's researches on the nature of the ego-ideal or super-ego. The inevitable result was that, whilst psycho-analytic technique was freed from the usual clinical preconception of interference, it has been at times hampered by theoretical views about stages and by pre-conceptions in regard to ego-structure.

At this point we must make a brief incursion into theory. As has always been the case, understanding of libido-development has been in advance of our knowledge of ego-structure; hence it is easy to illustrate the organization of views of analytic technique from the libido point of view. Here analytic processes fall easily into three phases—(*a*) *the development of the transference;* (*b*) *the transference-neurosis;* (*c*) *the solution of the transference.* But the moment one begins to examine different ways in which this hypothetical first stage develops in practice, it is obvious that another mode of classification is equally possible and almost as essential, viz.: an ego-classification. For example, one patient commences with every sign of freedom, talks easily and fluently; another talks easily and fluently with occasional sudden indications of stickiness, sudden relapses into silence, etc.; a third starts slowly, haltingly and with every sign of difficulty; a fourth can hardly be prevailed on to speak at all. Sooner or later we shall find in all of these evidence of similar mechanisms of defence, but there is obviously a sign here of different attitudes of the ego to the process of association. The fluent and halting types illustrate this difference most simply. But the difference can be noted in one and the same person. The second type I have mentioned, and of course all

patients at some time or another, talk freely and in a seemingly objective way, but are suddenly reduced to uneasy silence, as a rule without knowing why. Here it is evident that there are at least two ego-attitudes to be considered, of which one is not fully understood in consciousness. We now know that this second attitude is one taken up by the ego in obedience to the dictates of a special ego-institution, the super-ego. It is not proposed to deal here with questions of ego-structure: all we need to keep in mind about the super-ego is (i) that it is an institution built up in the ego on the model of previously external relations between parent and child; (ii) that this introjected parental institution continues to exercise supervision over instinct-impulse, is, so to speak, a sampling department for inner excitation; (iii) that, having delivered judgement, it depends for execution of that judgement on borrowed forces: it operates through the ego; (iv) that its operation is for the greater part unconscious. To come back to the case of the patient who suddenly becomes silent, it is evident that the silent pause implies a sudden change in the attitude of the ego in obedience to instruction received from the super-ego, in spite of the fact that in most instances both instruction and compliance, the whole process in fact have taken place apart from consciousness, which is presented with a *fait accompli*. At a later date we shall have occasion to consider how this among other difficulties has to be dealt with during analysis. To continue for the moment with the super-ego, we know what part it plays in relation to symptom-formation in the psycho-neuroses, how at its bidding the ego attempts to deal in some defensive way or other (e.g. repression, reaction-formation, regression) with id-impulses, how the ego is left in the lurch with insufficient forces at its disposal and makes a compromise which permits a return of the repressed in the disguised form of a symptom. Without going further into detail, we can see that, in addition to a libidinal classification of phases, different stages of analysis could be indicated by reference to the ego or to that special institution the ego-ideal. To return to the sudden silence, we have to consider not only the nature of the repressed excitation associated with the silence, but the attitude of the super-ego to such excitations and the capacity of the ego to obey the super-ego's bidding. It is easy to see that both the super-ego's attitude and the ego's obedience are based on antiquated systems of adaptation, and that an essential part of the treatment relates to uncovering this archaic unconscious attitude of the super-ego, tracing the factors in the child-parent relationship which has led to this particular set of attitudes, and so

freeing the ego from the necessity of carrying out various defence-manœuvres. In other words, we might subdivide the process of analysis in accordance with ego-standards. Thus *the first stage would be one of relaxing the archaic severities and watchfulness of the super-ego, the second the analysis of super-ego development and structure, and the third preparation of the ego to effect widened or unaccustomed adaptations, to hold unfettered the balance between inner tension and external release.*

So far we have considered the subdivision of analytic processes from the theoretical point of view, but it is easy to shew that these points of view are no mere abstractions. Within the past few years we have seen both tendencies illustrated in the views and technical suggestions of psycho-analytic writers. We may consider briefly two examples: first, the views at one time expressed jointly by Ferenczi and Rank, and the conception formulated by Alexander. The former regarded analysis as a process within the libido-development of the patient having individual form. They divided it more or less rigidly into stages: one in which libido is withdrawn from the ego-outposts (character, personality, etc.) and is concentrated in the analytic situation; the second when concentration is completed and infantile libido is expanded and worked through in the transference; and the third where the ego is weaned from the new libidinal situation and turned to reality. You can see that this is mainly a libidinal subdivision, although ego-factors are obviously taken into account in considering the processes of resistance in each stage. But the result of taking this point of view was reflected in the analytic procedure suggested by the authors. In the first stage a certain amount of ' activity ' was necessary to call in libido; in the second, expansion of infantile libido involved the use of prohibitions and observances; and in the third an arbitrary period was set for the termination of analyses, which constituted a final weaning and during which the process of fresh adaptation to reality had to be encompassed.

We are not concerned here with the validity of active procedure or justification for it; as you may know, Ferenczi has modified his terminal technique in some respects, whilst Rank has proceeded towards extreme amplification of his ' birth technique '. All we need note here is how this theoretical division into stages can be made to serve two purposes: (*a*) to justify the introduction of additional technical procedure or of a fresh technique, and (*b*) to meet the desire for some formula which might enable analysis to be shortened.

Coming now to Alexander's views, the first of these is that he sets

his measure by ego-standards. Libidinal factors are of course taken into account, but the main aim of psycho-analytic technique is expressed in terms of ego-organization. The super-ego is an anachronism in the mental apparatus. It deals with instinct by an archaic reaction system, which has most of the adaptation drawbacks of a reflex action. It must therefore be the aim of analysis to remove this anachronistic organization, and to make the ego take over the functions of the super-ego. This is carried out in two stages: by virtue of the transference the original childhood-relationship, as the result of which the super-ego was formed, is reproduced in analysis and the analyst is made to play the part of the super-ego to the patient's id. So far the patient has no great objection; in fact he is distinctly relieved, and begins to permit expression of barred instinct tendencies. These are ventilated but, instead of being gratified, are brought into genetic relationship with infantile memories or reconstructions. At this point the second stage has already commenced: the ego is being educated to normal libido-control. This is where the real resistance commences: it is evidenced by a series of regressions but these same regressions throw light on the processes of formation of the super-ego, and have to be analysed through before the patient is ready to live a free and unaided existence.

Once more we have no immediate concern with the accuracy of these views; we have, however, to note that in taking this ego-standpoint Alexander is free from any necessity to relate his analyses to stages of more or less fixed duration. He has also, I imagine, bound himself not to play the part of the super-ego during the stage when the patient projects this rôle on him; i.e. he can ventilate and corrollate but not gratify, so that by implication any recourse to active measures of whatever kind should be limited to his last stage, and moreover it would seem that his disintegration of the super-ego promises lengthy analyses. However this may be, I think that to some extent he might be said to limit his technical freedom of action by his theoretical views. Now the burden of all these theoretical considerations is simply this: that *whilst the existence of a special analytic situation is common to all conceptions of the analytic process, in the present state of our knowledge we are under no immediate obligation to measure this by rigid standards.* I would go further and say that whilst it is important to have more general understanding of different phases and their characteristic or prevailing mechanisms, it is a positive obstacle to the success of one's first analyses to commence studying the situation with too rigid pre-

conceptions as to their form and course. If practice consisted solely of classical transference-neuroses it might be possible to do so, but even then the method would have all the inaccuracies of a diagrammatic representation, or the disadvantages of studying ethnographic relations by means of a political map. Besides it neglects the essentially labile nature of the processes concerned. Take for example the modification or, if we prefer the theory, the disintegration, of the super-ego. It is clear that this process, which is generally associated with the later developments of analysis, has commenced from the very first day. The encouraging impersonality of the analyst and his absence of reaction to preconscious or other material is at least an open invitation to fresh introjection on the part of the patient. Never in the latter's experience has such a unique relationship existed for him. Take again the fact that, whilst our early work is mostly by way of establishing free association, we can never abandon this method up to the very last moment of analysis. We are prepared to find in the last regressional defences of analysis the same mechanisms functioning as in earlier uncovering of positive instinctual drives. Indeed, one of the main advantages of having a bird's-eye view of stages in analysis is that we may be able to distinguish between different causes for mental defence-functioning.

At any rate, if for the sake of convenience we carry in our mind a loose skeletal structure on which to deck out or extend the analytic situation, we must be constantly prepared to revise our judgements. One occasionally hears the comment: 'I analysed so and so's castration-complex thoroughly and yet the other day he or she showed quite active castration-reactions'. Now apart from the theoretical consideration that where a castration 'complex', so-called, has been thoroughly analysed, the neurotic kernel has been for the most part resolved, this attitude will serve to illustrate the point of view I am presenting. On the one hand, the analyst may have been misled into thinking that the gist of the matter has been uncovered, in which case he must revise his estimates and continue the process of working through. On the other hand, he may be in the right and his patient may be playing up by regression, in order to stave off approaching termination of analysis. In many cases it is difficult to be certain, and in such instances the analyst will be on safe ground if he takes the first view. At any rate he will by so doing avoid the somewhat fretful assumption that at a certain stage of analysis it is positively inconsiderate of the patient to have any castration remainders.

To return once more to the question of attitude, this must be one of expectant interest in situations which, although they have much in common, unfold in a great variety of unanticipated ways. I think perhaps the difficulty of the diagrammatic or anatomical view of analysis, which has so many natural attractions, can be neutralized by cultivating *a sense of movement.* The phrase is inadequate in many respects, but it corresponds roughly to our view of the dynamic forces and regulations of instinctual flow.

And here I think we may bring forward one last consideration which should affect our attitude to analysis, viz. an appreciation of the silent strength of these same instinctual forces. In *The Ego and the Id* Freud compares the relationship of the ego and the id with that of a rider astride a horse. He was of course careful to emphasize the original identity of the systems, the ego being a highly specialized part of the id, but the comparison is one of great significance to the commencing analyst. The late Dr. James Glover used to say many years ago that the attitude of an analyst to his case should be that of an onlooker who sees a baby perched on an elephant, trying to convince itself that it is master of the situation, yet compelled to give terrified acquiescence to any change of direction initiated by the more powerful locomotive force beneath it. The application of this is twofold: it is creative of analytic understanding to regard the ego as a dependent organization, and one is well-advised to treat the instinctual drives of the id with some of the respect and caution which is traditionally accorded to the 'rogue' elephant.

II

THE OPENING PHASE

Since the consultation (or interview) which is a necessary prelude to actual work epitomizes the whole analytic situation and method, we may with advantage consider it in some detail. What distinguishes it from the ordinary consultation is the fact that we permit and encourage the patient to tell his own story. The clinician, in his anxiety to clinch the diagnosis of organic disease, can afford sometimes to keep his patient 'to the point' and remain indifferent to the psychological tension he thereby produces. The latter, more often than not, goes off in a semi-explosive state of suppression. At the very most, his own views and theories have been met with indulgent indifference, and he resents bitterly the tacit assumption that his relation to the disease in question is simply that of a carrier. In the analytic consultation, apart

from non-committal social gambits, the first real move is up to the patient, and many useful deductions may be drawn from his bearing, mannerisms and the order in which the story unfolds. But in the consultation, especially when it is essential to arrive at some immediate diagnosis, we can see that some interference is necessary. The patient has been unconsciously repenting his temerity ever since he rang the bell, and we may be sure that there will be a good deal of condensation, displacement and secondary elaboration in his statement of the case. A few leading questions will usually serve to uncover the existence of symptoms or peculiarities or conflicts, as far as it is necessary or possible to do so. Even where an interview with a parent is a preliminary to actual consultation with a child, and where one is free to go into the whole question, it is advisable to adopt the same attitude, to encourage free association, following this up by more inspired stimuli. The results of the passive attitude can be quite amusing. A mother recently interviewed me with a view to examining her daughter, who had had a chequered school career. The case presented quite a serious reality problem, and the history as she related it indicated apprehensions on the part of various school authorities concerning the girl's sexual development and practices. I drew her attention to this in the later part of the interview with no result. Next morning a letter arrived stating that she had forgotten to tell me the girl had contracted the habit of masturbation. Generally speaking, where the diagnosis can be easily made or where a case is transferred after examination by another analyst, it is unnecessary to begin digging for history. Nevertheless I think it is advisable as a prelude to the first session's analysis of all transferred cases, to hold a brief, formal consultation in which patients are asked to indicate their reasons for coming to be analysed. This procedure will help to modify to some slight extent the patient's reading of the transfer, i.e. that the analyst is a second-rate makeshift. In any case the usual details as to fees and appointments will then be considered. Here again it will save a good deal of trouble later if very precise indications are given : e.g. the principle of ' letting ' one's time irrespective of actual attendances by the patient, the length of the session if that should vary, the question of a fixed or varying hour of attendance, the extent of holiday breaks. On these and all similar points it is well to have a settled policy, and on the whole I would make this suggestion to those starting to fill up their time-table : within reasonable limits decide and act as if your time-table were as full as you would like it to be. By so doing you will throw into relief any

tendency to subjective motivations. After all, whether your time is fully occupied or not, you are going to be told in hostile moments by would-be 'only children' that they shrewdly suspect you have only one patient.

The ideal attitude in consultation is, then, to get the patient to talk and only to speak oneself when it is necessary to elicit further information in order that one may decide on his suitability for analysis. A certain amount of explanatory conversation may be unavoidable, but it should be reduced to a minimum. When the patient is already in possession of some information concerning the nature of analysis, it is usually possible to conclude the interview without going into any technical matters. But in some instances a patient may submit the analyst to a searching cross-examination as to the method of analysis. This is of course an anxiety-attitude, and our policy should be to give some general information calculated to meet this anxiety for the moment, but as far as possible not to go into technical details which later on will be turned to disadvantage when the patient begins to 'resist'. The reason for this procedure is not so much that for all practical purposes it is universally adopted by consultants, but that in analysis it is exceedingly important to get fresh impressions of the patient's reaction to the analytic situation. Early explanations simply result in blurred impressions.

There is, however, one question which is almost invariably propounded by the patients, usually when the subject of fees is broached: how long will the analysis last? As we shall see later, this is a point on which the analyst himself may be subject to unconscious bias. As far as the patient's interests are concerned, there are only three possible replies. Either we say that we do not know, or we say that we do not know but that if the matter is urgent we can give them a rough indication after some weeks' analysis, or we say that, whilst we do not know, they ought at least to budget for a minimum period. This last is the most unsatisfactory of the replies: the minimum indicated can only be determined by our rough-and-ready diagnosis. We may, for example, tell an anxiety-hysteric that with reasonable progress the case may require a minimum of nine to twelve months, but suppose we find later that there are some psychotic mechanisms underlying the hysteria, the estimate will be entirely falsified, and will be made a subject of reproach or depreciation by the patient. Nevertheless we may be compelled to give some such estimate, in which case it must be given subject to qualification. If they go on to demand reasons, it is

easy to show patients that they are asking the impossible. After all, this is an occasion when we can learn much from the consultant who is approached on the subject of organic disorder. Of course the latter is considerably assisted by the fact that sufferers from organic illness, to begin with, at any rate, desire to be treated until they are cured, and it does not usually occur to them to stipulate as to the length of the doctor's attendance. If they do so inquire, if, for example, a consumptive in the early stages of his disease asks how long his treatment may last, the doctor knowing that in the early stages no prognosis can be arrived at may promise to give a rough opinion in six *months* (not weeks). His experience tells him that at the best he may have to mortgage his patient's time for the whole of one year and the greater part of two subsequent years, but he also knows that at the end of five years his patient may still be under treatment and still with a favourable prognosis ; or again that at the end of ten years he may be watching a fatal termination. So without a shade of uneasiness or a qualm of conscience he consults his patient's interests best by giving a guarded prognosis and ample warning of the provisory nature of these estimates. The psycho-analyst can do no better than follow his example.

Assuming now that the formalities are completed and that the patient is about to be ushered in for the first analytic session, no sooner does the door open than we are presented with our first problem in technique. How are we to greet him ? Shall we shake hands or not ? The decision is not perhaps momentous, but it involves consideration of certain principles. One at least, that of counter-transference and resistance, we can delay for an appropriate occasion : all we need say at present concerning the analyst is that there are individual and temperamental differences in attitude which make for elasticity in formulating guiding rules. As regards the patient, we have to remember that the significance of a handshake is very different for an hysterical, an obsessional or a depressed case. In fact it might be said that the deeper the patient's regression or the earlier the fixation, the more significant do such details of analytic behaviour become. For the hysteric a handshake may be a promise, for the obsessional a challenge, for the narcissistic type it may be an attack. On the whole it is advisable to omit the procedure, at any rate with all who show negativistic reactions, and in most cases not to have too formal a leave-taking at the end of the session. After a period of emotional stimulation, a patient may reasonably hope to leave the room unembarrassed by any procedure reminiscent of scrutiny. With these reservations the

matter is one for individual inclination and tact. Whatever course is adopted, it is essential that it should be consistently carried out. An exception to this rule would exist where the analyst thought that the transfer of affect to the analytic situation was insufficient, that the patient tended to make the whole affair as impersonal as possible. He could then intimate that in future he intended shaking hands. As you can see, this involves the principle of ' active ' therapy and must be considered later. Otherwise consistency of demeanour is essential during all periods when the analyst is, as it were, under observation, i.e. at the beginning, end of and, in case of interruption, during the session. The tendency of hysterical types is to make a convenience of these preliminary moments by easing their burden of phantasy before free association on the couch has commenced. Certain elements are automatically projected on to the analyst, and it will be found that these serve at the same time the purpose of giving dramatic representation to unconscious wishes. This is not so apparent at the very beginning of an analysis, but sooner or later the session's work will begin with comments of this sort, ' Why did you look at me in that peculiar way when I came in ' or ' What have I done that you should frown at me . . . ' or ' look severely ' . . . or ' appear worried '. . . . The fact is, of course, that the patient is really frowning at himself, lessening internal conflict, by reconstructing a situation in which the parent taxes the child with guilty conduct. But it is more than a mere projection : the patient is also dramatizing an erotic phantasy, in this case of a masochistic sort. The parent has frowned at (attacked, punished loved) the child. Obsessional types do not as a rule indulge this play with the analyst as object quite so openly ; nevertheless it will be found that either in the waiting-room, or on entry to the analytical room, or on the way to the couch fragmentary phrases or compulsive words or mental comments on some arrangement of the room flit across their minds, to be followed up by a silent pause on lying down. Narcissistic cases give the impression that only an earthquake would momentarily deflect their attention from the purpose in hand, but this may be a false impression. Actually you will find that their attention is often deflected by some isolated object in the room, and that during later association their minds are ceaselessly busy in an undercurrent of speculation about it. On occasion the march to the couch may itself be interrupted. One patient was in the habit of walking boldly and erectly to the couch, stopping on the way to warm one hand (partly paralysed) at the fire. He did so regularly, until once too frank a gesture was given by his id

having warmed the hand, he straightened himself up and began to march boldly out of the room, caught himself half-way and, with a furtive sidelook at the analyst, literally slunk on to the couch. Another was at first with difficulty induced to lie down : his preliminary protest took the form of strolling to the fireplace, warming himself leisurely, beaming on me with benevolent eyes and propounding the solicitous inquiry, ' Well, how are things ? ' My first response was a non-committal noise, the next step was a series of explanations on succeeding days, and the third a policy of silent observation which finally wore down his affable obstinacy. Even then he was by no means ' on ' the couch in the literal sense ; his right foot was firmly planted on the floor, giving him a reassuring sense of security. He had not abandoned *terra firma*, and should it be necessary to bolt he had at least a good take-off. But I was content for the moment with having reduced his conscious dallying on the hearth-rug : the couch position could wait until a later occasion. *A patient need not be harried ; there is an absorption-point for all cases ; to exceed this is unnecessary, usually superfluous and sometimes inadvisable.*

Once the patient is on the couch we lose no time in explaining the nature of analytic procedure, making him acquainted with the fundamental rule that he shall say whatever comes into his mind, irrespective of emotional or other valuation. Having stated this quite explicitly in the plainest terms, we may in most cases await events. In some instances, however, it may be worth while to expound the rule briefly by means of some simple comparison of the usual type, e.g. an imagined experiment in which someone is asked to describe to a blindfolded geologist the view as seen from a carriage window, when obviously the omission of any feature on grounds of triviality or lack of æsthetic attraction might prejudice the accuracy of the indirect geological survey. *It is scarcely an exaggeration to say that from the moment the fundamental rule has been expounded to the patient and has been ostensibly accepted by the latter, a large part of the analyst's work will up to the last moment consist in an endeavour to circumvent its evasion.* Evasion tendencies are of course more apparent in the earlier stages, and we may well proceed now to discuss some varieties, particularly those which call for action on the part of the analyst. We may consider first those individuals who seem to take to the method like a duck to water. They plunge straight into the matter and associate to all appearance in a commendably free manner. Or, consciously guided by some preconceptions of analytic aims, they produce an elaborate autobiographical

record ; or again, evidently on the assumption that possession is nine points of the law, they endeavour to ensure that there will be no analytic nonsense about their analysis by seizing the reins, combining a free output of associative material with a seemingly detached survey of what they have just produced in terms of the latest analytic theory with which they are familiar. This is all very well and good, and there is no immediate necessity to interfere : sooner or later the id will have some say or ego-defences will become apparent. Indeed, the first indication for the necessity of early interference in such cases is mainly a negative one, i.e. where the flow of associations continues uninterruptedly *without* any such signs. There is also a positive indication ; it is a sort of eddy in the current of association, where the patient after covering a certain amount of ground begins, as it were, to chase his own tail, talks quite as fluently, but brings no additional grist to the mill. But even if we decide not to interfere for the moment we may legitimately draw some deductions for future reference, or at any rate make some mental notes of interrogation. Of these the indications of a positive attitude, submissiveness, amiability, etc., are less important than the hostile tendencies they cloak. We have to consider the play of narcissistic tendencies, the hostility to analytic method implied in biographical recital, the attempt by doing their own analysis to hoist the analyst with his own petard, to out-Herod Herod. We may draw preliminary deductions as to the relative importance of certain phases of pre-genital development, e.g. the urethral erotic implications of certain loquacious types, the anal implications of any tendency to round off each session with a completed narrative. Having done all this, we may mentally check these deductions by considerations of another kind. *We must observe the amount of affect accompanying the associations.* Obsessional types we shall soon find weaving interminable circumlocutions proceeding in a series of loops, and at the same time touching on certain intimate matters with a seemingly detached air as if immune from any emotional implications. Narcissistic cases, on the other hand, although exhibiting a tendency to anchor round a stereotyped set of associations, display from time to time a considerable amount of feeling. Hysterical types are so free in expression of affect that they can scarcely be said to illustrate the difficulty we are considering at present, viz. the difficulty of fluent and effortless association. As we shall see later, their associations are punctuated with emotional asterisks, and we are never left very long in doubt about the necessity of coming to their assistance. One particular type of case

may however give rise to some confusion, i.e. where hysterical manifestations are superimposed on narcissistic ego fixation. Here we may observe a process of circling in associations, which must be given more scope than in the instances previously described. Those patients' ego systems are less tolerant of phantasy products, and the circling represents an attempt not only to distribute the affective charge more widely but to deal with it by a process of repetition, to which we shall pay more attention when considering the process of ' working through '. To come back to the matter in hand, it is important to check all our preliminary observations of the nature of associative material by an estimate of the amount of affective discharge. Needless to say, we acquire the habit of making these estimates in all cases, but it is essential to do so where we have reason to conclude that the patient is adopting the policy of the ' stay-in strike '.

So far we have considered the difficulty presented by too easy association. We may now turn our attention to those patients who find the association technique a stumbling block and who either appeal for assistance, or without asking for help proceed in a dumb, driven sort of way from halt to halt. Now in regard to offering assistance, two things have to be remembered : the first is that in some way or another all patients coming to be analysed require assistance. The second is a precautionary consideration. All patients, in their unconscious anxiety to be freed from the discomfort of free association, may be depended upon to try turning the tables on the analyst, and this will be achieved if they can get him to abrogate his own rule, making it easy when it is plainly *not* easy, talking when *they* wish to be silent or encouraging them at the beginning to follow up some line of thought which appears analytically promising. The difficulty is to combine these points of view. Of course it is clear that the only real assistance one can give is that of accurate interpretation at the appropriate moment, but at the commencement of analysis the opportunities for deep interpretation are few and far between. What we are more concerned with is the necessity to ' get them going '. When one is asked innocently ' How shall I begin ? Shall I tell you the story of my life ? ' etc., the answer is easy : ' If you care, *begin* to do so provided you *continue* the narrative in accordance with the rule '. This they will soon find is not a very material concession, and all so-called concessions which automatically set the rule in operation may be included under the heading of legitimate advances in difficult cases. But how are we to judge of true difficult cases. Roughly speaking, there are two standards, (1) where

you come to the conclusion that the patient is suffering from acute anxiety and apprehension, and (2) where there is evidence of ego-disorder, as for example in marked depression. In any case one should not too readily weaken the strength of one's own position, which lies in listening, even to silences. In the average case more will be gained by waiting, with at the most monosyllabic encouragement to speak. Incidentally the encouraging ' Yes ' should be reserved for occasions when encouragement is called for and when it is appreciated. Patients are quick to spot a parental tolerance (or impatience) behind the superfluous ' Yes ' and to resent what they regard as pure smugness of outlook.

Now there are certain cases which seem to defy all rules and where decision as to the course to pursue is exceedingly difficult. These are the cases sent under duress, frequently though not always minors, also some alleged ' character '-cases, where the main indications seem to have been a negativistic incapacity for adaptation, leading to clashes with various authorities. Here one may be compelled to come out into the open and the problem is : along what line should one advance ? But first of all, what are the most important factors operative in such instances ? I think it is agreed that they are twofold, the intensity of guilt-feeling and the ' instability ' of ego-ideal or super-ego formations. Such patients preserve themselves from anxiety and conflict by a sort of massive projection, the guilt-situations are cloaked behind real contingencies, the punishment is distributed between the self and external objects, but appears to be initiated by external objects.

We can see that such a patient has every unconscious reason to fight shy of analysis, that this combination of unconscious guilt-feeling and hostility will produce the most obstinate of all resistances, and that in some respects this ego-organization has a dangerous resemblance to that of the psychotic. Our policy must then be to abandon the expectant method we adopt in less difficult cases and at the earliest moment to alleviate the more immediate manifestations of guilt, following this up by interpretations of unconscious phantasy, which we should otherwise delay until a more favourable moment. In the first instance we direct our attention to the patient's unconscious *ego attitudes*, focussing them in consciousness, whilst in the second we deal with the *phantasy material* which provokes these attitudes. Here we have our first hint of the difference between ego-analysis and libido analysis. Now the manifestations of guilt may be easy to demonstrate from the patient's varying reaction to different types of preconscious material, or, as is

more often the case, his guilt is cloaked by a mechanism of projection. In the latter instance all we have to go on is direct or indirect evidence of hostility to the analyst. Having ventilated the hostility, we must then demonstrate its defensive significance, going on to indicate what appears to us to be the most immediate source of unconscious guilt.

But what if the patient doesn't speak, or hardly speaks at all? What is one to do? Now here is an investigation which is open to all comers irrespective of experience. I cannot profess to indicate any solution. My own practice is to start in the usual way, but on the appearance of difficulty to be a little more explanatory and encouraging, coming, as it were, part of the way to meet advances, but returning at once to the passive attitude when any advance is made. Failing any progress, the choice then seems to lie between making our explanations more and more interpretative, emphasizing their attitude of defensive hostility to ourselves, and at the same time pointing out the infantile sources of this attitude. Or, adopting the method which has been used so successfully with children by Melanie Klein, we can use the direct interpretative method, translating into unconscious terms whatever fragmentary ideas are presented to us, or in the absence of spoken associations, any actions or lack of action which we may be able to observe. The difference between these methods is really only quantitative, a matter of graduated dosage. In Mrs. Klein's method we are less dependent on the spoken word, but success in both policies depends on the accuracy of our transference interpretations. In any case, whether we proceed gradually to deep interpretation or have immediate recourse to transference interpretation of heavily charged unconscious attitudes, the main point is that we should in the opening phases never get too far away from the passive expectant attitude. All that I have dealt with so far is the extent to which we may depart from it in order to 'get things going'.

Now it will naturally occur to you to ask, *à propos* of the last case, 'Why not tell him he is resisting? Obviously there must be some strong hostility underlying his attitude to association'. The reason I have not mentioned the word so far is partly one of convenience, viz. that I hope to give a general view of resistance under the caption of defence. But there is also a practical reason. It is quite true that the difficulties presented at the beginning of analysis are resistances: as Freud has said, 'Anything that interferes with the course of analysis is a resistance'. But to say to a patient at the outset of analysis that he is resisting is not only to focus his attention on a theoretical concept

before he can understand it ; it is an attempt to remove an obstruction by means of a cliché. One might as well say to someone who blinks his eye in a sandstorm, ' Your conjunctival reflex is working, please keep your eyes open '. After all it is the function of the ego-system to resist, and indeed one of the indications that we must be on the outlook for resistances is the fact that no signs of resistance appear : e.g. the case of fluent associating. In fact it pays to fight shy of using technical terms at any time in the analysis. The result of using them is usually to provide a few more toys for the constant process of word-play which all patients indulge in to some degree. An accurate interpretation is much more effective than a reference to ' resistance ', which is usually felt to be an accusation. The explanations we give at the commencement of analysis should where possible embody some interpretation along with reassurance, and it is here that the usual methods of expressing early unconscious defence can be ventilated. Theoretical conceptions are necessary, but may be employed with more effect when a whole position has been uncovered and when it is convenient to assemble the multitudinous representatives of a complex or defensive mechanism. I would suggest that the word ' complex ' or the use of special nomenclature such as ' the castration complex ' should, if at all, be used only when we are ready to demonstrate the meaning and purpose of the particular complex.

Up till now we have been occupied solely with examples of special difficulty which may arise at the beginning of analysis, and have neglected to pay any attention to opening phases of an uneventful type. Experience gained from the study of difficult cases stands us in good stead, however, in the handling of ordinary types. It is rare to find a patient proceeding quite smoothly through the opening phase up to the point when transference difficulties arise. Observation shows us that the same mechanisms are at work as in refractory patients, and making due allowance for difference in degree, the same methods are used in overcoming obstacles. When the flow of association is choked by embarrassment, we share with the patient the discovery of a new or reinforced ego attitude. We reverse a projection here or explain an identification there. When after stumbling utterances on, let us say, the subject of masturbation, the patient dwells on the obnoxious characteristics of authoritative figures in his environment, their tendency to unwarranted interference or unfair criticism, we are able to relate these reactions to the immediate stimulus, to touch on the defensive side of hostile reactions to ourselves, and to connect hostility with

anxiety. These are of course interpretations and operate as such, but we have not been under the necessity of making deep interpretations of unconscious phantasy, and the patient is reassured by what he regards as encouraging explanations. This, for the moment, is the effect we wish to produce. Each explanation should give just the right amount of impetus, should guide the patient deeper into the current of spontaneous association, before he has the opportunity of taking fright and darting back to the bank in a state of suspicious and hostile panic.

It is now high time to take stock of the analytic situation. How far have we progressed and what have been the mechanisms involved? We will assume that either spontaneously or as the result of our assistance the patient has been 'got going'. We may assume further that he keeps going for some time. What has he given us and what are we to do about it? I think we may take it that the patient has unburdened himself of a considerable amount of preconscious material, has presented us with a considerable number of 'screen-memories', and has shown us a specific tendency to '*drift*' in some direction or another. On the other hand, this 'drift' may have been indicated in a negative sort of way. Let us take, for example, manifestations of the castration complex. From the beginning we may have observed that whilst the first part of the session has been characterized by general tendencies, the end has persistently dealt with ideas of injury, mutilation, imperfection, feelings of hopelessness or pointlessness, and so on. We may have observed that whenever one association pointed in any of these directions, a pause recurred or an obvious switch in the associations was made. But though we may already have suspected all this at the actual consultation or first interview, our main objective has been the free expression of this material. It is not yet time to drive home the persisting psychic reality of such situations; indeed we cannot do so in any convincing way until that position has been established which we shall describe under the heading of 'transference neurosis'. But you will legitimately ask, 'Have there been no signs of transference already?' Most assuredly: the decision to arrange a consultation was in itself evidence of a transference situation, and at that consultation the decision to undergo analysis was affected by earlier and immediate transferences, which were, on the balance, of a positive nature. Patients with a predominantly negative transference may go so far under the original impetus as to arrange for analysis, but are liable to write a week later postponing the step on various rationalized grounds. They never come back.

When the actual analysis begins the balance of positive transference of a spontaneous sort, the ' floating ' positive, we might say, has enabled us to get through many of the initial difficulties, and our interpretative labours have been directed largely towards manifestations of the ' floating ' negative. These are very vague and elastic terms, and there is no essential distinction between transferences in earlier and later stages, but I feel convinced that *the first crisis in analysis occurs at the time when these preliminary transferences merge in an imperceptible way with the transference of affect brought about specifically by the analytic situation and its fundamental rule.* At this point symptoms may improve, sometimes disappear, or previous signs of hostility may begin to exacerbate ; in fact, it is at this point that analyses are often broken off. A patient may feel better, seem to have gained his objective and goes his way in seemingly grateful rejoicing ; or he may find that he wants to get married and must save up ; or he establishes some unconscious homosexual attachment and finds analysis ' very interesting,' but of no great moment. Or he finds that he wishes to take up a fresh occupation precluding his attendance at analysis ; or he feels that his symptoms have a purely physiological basis which requires priority of attention. He may in short produce some one or other of the many forms of diverting libido from the analytic situation, and, in default of these, simply indicates that he will no longer continue his attendance. Such patients provide some of the most interesting material for reflection and investigation, quite sufficient to compensate for any tendency on the part of the commencing analyst to regard his career as shattered. After all he can take comfort from at least one consideration ; he has been prepared to go on. He has not had resort to those large gestures of defeat beloved by his clinical colleagues. He has not sent his patient on a voyage or to the country, or brought his difficulties to a head by roundly abusing his patient's tardiness in recovery.

At this point I feel myself considerably hampered by the necessity of compressing into a brief space, a description of *movement* in analysis, and at the same time of taking sufficient cognizance of practical difficulties. I want to suggest to you the main purpose of the opening movement, viz. to set the analytic situation going, to remove obstacles from the progress of association, to permit unconscious drives to influence selectively the flow of ideas, to watch in what way the patient's pleasure-principle tends to operate. At the same time I should like to defer for a later date a systematic consideration of

defences, in order that we may get a grip of the essential identity of various defensive functions. The obvious risk is that I may give the impression of underrating the early defences. For example, when I say that there is a critical point in the opening phase of analysis, I do not intend to suggest that the crisis cannot be avoided or overcome, as if the analyst had nothing else to do but to set the wheels agoing, remove obvious pieces of grit and trust to luck for the rest. In many cases the work done in furthering association will in itself be sufficient to carry the patient over the first stile, and perhaps it might be said that the optimum amount of interference in the opening phase is that which keeps the associations going and at the same time ventilates the defensive hostility to analysis (and therefore to the analyst) produced by the progress of associations. But in a varied analytical practice we have to budget for every variety of refractory case, especially for patients whose defences to analysis are almost but not quite insuperable. Other conditions being equal, i.e. there having been no marked change in the patient's libidinal *milieu*, these cases should get over their first difficulties without breaking away, but this implies certain analytic dispositions on our part. I think we may safely say that the exceptional cases we have already described as presenting difficulty with the association technique at the beginning of analysis are not as a rule likely to give so much difficulty at this critical phase. As we shall find in discussing resistances generally, it is fairly true to say that the toughest and most effective resistances are silent. In the case of the first group the manifestations of resistance are in fact extremely noisy ; in the second group they are liable to be overlooked on account of their silent activity. It is often the case that at the beginning of analysis we have no valid criticism to make of the operation of the association technique. The patient is neither too ready nor to inhibited. He talks on the whole freely ; but we have the feeling that the entire process is artificial, that he is as it were setting his teeth to carry out an experiment and that he is determined that the experiment will fail, though from no ostensible fault of his. But if we examine the situations depicted in his associations, we see that although they have to do mainly with current or recent observations, they represent some common attitude and that is an attitude of anxiety, as if preparing to ward off some danger. Or again, the general themes are of a kind which if closely examined are found to deal mainly with situations of submission, authority and discipline. To take a third example : the type of association may be beyond reproach, yet there

are various minor indications that the patient is tentatively trying to see how far he can go in subverting the analytical routine. He innocently inquires how far some previously projected journey will interfere with some future appointments or whether accommodation will be made by the analyst in case of office difficulties and so on.

Now the attitude of the analyst in the face of the last-mentioned situation is perfectly clear. His diagnosis and recommendation of treatment was an earnest of his view that the first necessity for the patient was psycho-analysis, and he must be adamantine in maintaining the attitude that analysis must always come first. But to be adamantine does not imply that one must throw disciplinary brickbats at the patient's head. Any formulations of this sort must be accompanied by an analytical explanation of the source of these resistances. And this enables us to amplify our description of the analyst's objective during the first phase of analysis. He has not only to get things going and deal with immediate obstacles, but he has to keep in mind that the whole of his patient's preliminary attitude to analysis is a natural exhibition of defence against the arousing of anxiety. Now the process of analysis, by giving free scope to unconscious presentation, is *a priori* calculated to stimulate all the possibilities of unconscious anxiety. This is only in part allayed by the favourable conditions present in analysis and by the non-critical attitude of the analyst, and where the general signs indicate that the patient is burdened by extreme neurotic anxiety, it is our policy to come forward with explanations which will tend to relieve him. In other words, if a patient should break off analysis during the opening phase, the more accurate description is not, ' he was too resistant ' or ' narcissistic ', but rather, ' his anxieties were too acute '.

You will observe then that, roughly speaking, there are two groups of difficult cases to be studied in the opening phase: (1) those who present immediate difficulty in commencing analysis, and (2) those who may seem to be quite amenable to the analytic process, but after a varying period show quite vigorous defensive reactions and are liable to break off. I am aware that this is a very inadequate classification, and one in which no cognizance is taken of mixed types of reaction. But I hope that it will throw into some relief the main problems of the opening phase. On the whole, once the members of the first group have been got going they will give less trouble until the transference-neurosis threatens to develop, and on the whole, provided we have been awake to their earlier unobtrusive defence-reactions, the second group can be tided over their critical phase.

But it is time to return to the average case in which no such violent manifestations are indicated, and to consider what period will elapse before the floating positive (or primary impetus) will exhaust itself. It would be unsafe to pin oneself down to an actual period, often it seems to last from a few weeks to a few months. It is difficult to say, for the reason that it constitutes only one factor in the situation; obviously the degree of subjective discomfort, the narcissistic enjoyment of self-expression and many other factors contribute here. I think, too, it may vary in extent in accordance with the amount of success which the patient has achieved in his unconscious playing up to the analytic situation and the strength of the impression he has formed, rightly or wrongly, of the analyst's determination to keep unswervingly to the purposes of free association. As you can imagine, there is no hurry to resist if no immediate danger is scented by his unconscious ego.

It is increasingly difficult to keep the word 'resistance' out of this discussion; one can scarcely mention any of the factors which operate in the opening phase without immediately thinking of a type of resistance originating from the same source. And when we start thinking of *one* type, we can see more or less conclusive evidence of the operation of every other type. Nevertheless it is quite reasonable to expect that if we talk of an opening phase we should be ready to indicate not only what the most important mechanisms are, but also which mechanisms are most likely to get out of gear during that phase.

I would suggest that there are two main factors operative in the opening stage. The first we have already mentioned in reference to the critical phase, the allaying of anxiety, and the second is the influence of the analytic situation in modifying the super-ego. The spontaneous allaying of anxiety is essentially related to a parental situation in analysis; the patient is in a sense in safety, and is encouraged to let affect and idea run together. It is unique in the sense that he is never given false reassurance; for the first time in his life, he has not been pooh-poohed, and becomes gradually familiar with an attitude which later on becomes displeasing, viz. that he has some *psychically real* cause for anxiety. Later on, he will himself begin to pooh-pooh the idea, will tell you that he never really felt so ill as he said, will tell you that you are on a false trail if you think he has anything else to conceal, and will adopt every conceivable ruse to write down the whole theory of psychic reality. But at first, driven by the inconveniences of a fettered ego, he is on your side.

The second factor, viz. the modification of the ego-ideal, also implies a parental situation, but is even more strikingly unique in another sense. For the first time in his life the patient can speak of the innermost concerns of his mind before a parental image that does not swoop on him with direct or implied reproof and correction. Further, even those matters to which he at first refuses house-room in his own consciousness, or which induce in him the strongest feelings of self-reproach, are treated in the same way. The analyst will not play the parental game, either when it is anticipated with distaste and dread or when it is eagerly sought after. In other words, he will imitate neither the external objective parent nor that to which the patient has given allegiance in his own mind, i.e. his super-ego. The patient for his part appreciates the one attitude but resents the other, nevertheless the result of a quiet maintenance of the analyst's attitude gradually bears fruit, and as the process of identification develops we are faced with partial accomplishment of one of the first necessities in analysis, a modification of the patient's ego-ideal. I say partial advisedly, because the real task is yet to come ; the modification requires to be deep and lasting, and this is not possible until the actual development of this ego-ideal has been unfolded in a real situation in the patient's analysis.

Now as to the specific resistances manifested in the first stage, it may be said that, in the general sense of repression, they are typical ego-resistances ; in so far as they are concerned with guilt-feelings, however, they have a specific relation to the super-ego—probably many of the immediate resistances to analysis are of the super-ego type. But it will be remarked : are not all resistances ego-resistances ? That is of course true in the sense that they operate or manifest themselves through the ego, but from the point of view of origin we have to learn that in the course of analysis at least five different types of general resistance can be observed. To these we must next turn our attention.

III

DEFENCE-RESISTANCE

As a prelude to the consideration of ' defence ' mechanisms, it may be remarked that on this occasion we are not primarily concerned with stages in the analytic situation. I imagine that in the discussion of the opening phase we did in fact cover the ground appertaining to the first stage of analysis. We might say that the main objectives were to allay anxiety, to allow for preliminary modification of the patient's super-ego, and thereby to permit a more or less unhampered development of the transference situation. I see, however, that by discussing ' Defence-Resistance ' immediately after ' The Opening Phase ', I may have created the impression that there was little or no defence in the first stage and that a defensive phase constituted the second stage of analysis. In one sense this is really the case. Such defences as are dealt with in the opening phase are so treated in order to clear the ground for more primitive representations of unconscious ideas, or, in terms of the association-technique, to allow primary processes to play their specific part in guiding the train of presentations. It is therefore true to say that the real disposition of the defensive forces will only begin to be uncovered towards the end of the opening phase. But of course, strictly speaking, a defensive phase is not a stage in itself. *Throughout the whole of the analysis the mind will exercise a defensive function.* We may remind ourselves too that, although the defences actually dealt with in the opening phase are chiefly those which act as obstacles to the unfolding of analysis, there are many signs of deep-lying resistances and many significant indications of the cause of these resistances. These have to be treasured for future reference, the time being not yet ripe for their complete interpretative handling. The exceptions to this procedure mentioned last time were such cases as prove seriously refractory to the ordinary analytic approach.

To get any comprehensive grasp of the problem of defence-resistance, it is necessary to approach the subject from many different angles. First of all, there is the *clinical* side of the picture, how

resistances appear directly or indirectly in analysis. Then we have to consider them in relation to the general mental *function* of defence. Next comes their special *relation to the phenomena of transference,* the fact that some resistances are part of the transference. Finally, we have to review the specific characteristics of defence in hysteria, obsessional neurosis, etc., and their *relation to fixation-points.* These constitute the lines of approach in so far as resistances have to be undermined and resolved ; but it will then be well to reconsider the functional aspect of resistances, in order to relate them to the principle of repetition and ' working through '. By so doing we may hope to correct any false impression which might tend to be formed as to their ' perverse ' nature. Throughout the discussion we shall assume that the analyst is free from unconscious bias.

From the *clinical* point of view, resistances are most simply divided into manifestations of an *obvious* kind and manifestations which are essentially *unobtrusive,* a classification following the histological one of macroscopic and microscopic appearances. The distinction has no scientific value, but will serve to call attention to the fact that the resistances which give rise to most trouble are seldom advertised. We might compare the obvious manifestations of resistance with crude slips of the tongue, in which the unconscious purpose is barely disguised, or with open manifestations of transference. In fact, many slips and transference-manifestations are nothing more than indications of resistance, the only criterion being the evidence of a defensive attitude, as distinct from the expression of a practically unmodified unconscious trend. Thus, when a patient intending to say ' Gaiety chorus-girls ' actually says ' coitus girls ', or when another intimates that something ' has come into his mouth ', meaning to say ' mind ', we have examples of obvious slips in which on the whole the libidinal impulse predominates. When another patient, after a disquisition on the habits of monkeys, takes up the thread of association with the phrase ' Now, donkey ', meaning to say ' Now, doctor ', we have an obvious slip in which on the balance the reactive forces predominate. So with crass resistances as a whole : their intent can scarcely be mistaken. They resemble the rashes and tumours of clinical medicine, which are recognized by simple inspection or palpation. The most crass of all resistances is of course where the patient decides to abandon analysis, but there are all sorts of modifications of this attitude. Patients may see to it that only a limited period is available for the analysis or take advantage of every well-rationalized opportunity to

absent themselves from analysis ; or there may be occasional absences on clearly inadequate grounds ; they may arrive late, either occasionally very late or frequently a few minutes late. Amongst the regular attenders may be noticed those who arrive in a flurry after taking the wrong bus or chasing down the wrong street, or after ringing the next door bell or walking busily past the door. Those who forget a changed appointment or ring up to have it confirmed are in the same group. Again, those who lag on the way to the analytic room, dally with one thing or another on the way to the couch, making affable conversation *en route*, are really of the same disposition, save that their positive cover is more marked. Then we have the obvious resistances to analytic technique, every variety of pause or circumlocution, automatic criticism and rejection on intellectual grounds of interpretations given, speaking inaudibly, gabbling, and so forth. Inattention may vary from slight hardness of hearing to falling asleep. Next we have to consider obvious deflections of libido from the analytic situation, in particular the attachment to love-objects of either sex, marked changes in interest and occupation, business entanglements involving financial loss, the exploitation of intercurrent or chronic organic disorder involving treatment at the hands of another practitioner. In fact, it would be easy to produce an extended catalogue of obvious resistances, classifying them according to taste, but the foregoing may be taken as a sample.

When we come to consider the more unobtrusive resistances, the classification is again a matter of individual taste, perspicacity or sensitiveness. Some analysts have a flair for detecting particular types of resistance and would naturally read minute indications of these on the run. For others it would be fair to say that less exaggerated expression of the defences described above would be regarded as unobtrusive e.g., minor pauses, slips, inattentions, circumlocutions, etc. Nevertheless, I should be inclined to say that, although we must be constantly on the alert for such minor indications, they do not constitute the most important part of an unobtrusive group. *The most successful resistances are silent, and it might be said that the sign of their existence is our unawareness of them ;* in other words, resistances exist which we are able to detect most often in retrospect, and of which we first become cognizant either on account of a slowing of progress or because of some more or less explosive break-through in obvious forms. On the whole, the characteristic of these unobtrusive resistances is just that they are not explosive, do not break through or disrupt the

superficies of the analytic situation, but rather infiltrate the situation, exude through it, or, to vary the expression, move with the stream rather than against it, snagwise. A few examples suggest themselves here. There are many isolated occasions in analysis and many continuous periods when the patient seems to conform to all the requirements of analysis. He has talked freely, moved from subject to subject in a way which seems to suggest a continuous thread of underlying connections, has dealt with some emotionally-toned ideas, primitive interests, or early memories and phantasies. On isolated occasions the signification of this behaviour passes unnoticed, but when the same process continues over a longer period, it sooner or later dawns on us that we are experiencing a 'doldrum' variety of resistance. The point of interest to us lies in the phrase 'sooner or later'. Again, a patient comes along and day after day becomes immersed in a train of emotional associations with every evidence of affective discharge; the unconscious subject-matter seems easy to appreciate: it may be a question of anal or exhibitionistic preoccupation or the ever-present subject of castration-anxiety. One seems to be 'getting on' or, to take a more modest view, the patient appears to be progressing satisfactorily, aided or unaided by our interpretations: gradually, however, it begins to dawn on us that instead of moving forward or backward we have been practically at a standstill for some time. It is as if we had been watching under a magnifying glass a piece of radioactive material, shedding constant emanations without any obvious diminution in weight. Now there are many possible explanations of this state of affairs, but to describe them all in immediate detail would anticipate conclusions which can be formulated more conveniently at a later stage of our discussion. Let us assume for the moment that there is no evidence of *bonâ fide* 'working through'. We are then thrown back on three main possibilities: (1) the patient may be trying to screen an entirely different subject by this deployment of forces, offering up a vicarious sacrifice, e.g. of genital images in favour of anal images; or (2), as James Glover pointed out, we may have been blind to one of the patient's exploitations of the transference-situation, to a sort of exhibitionistic orgy. It was not so much the anal or genital images that mattered, but the gratification of an exhibitionist tendency in the transference; or (3), the patient is dramatizing an infantile situation, e.g. of mistrust or disappointment, rather than remembering it, and at the same time covering this dramatization by displacement. The reiteration then means 'This

situation was never put right in the past, so it can never come to an end'. Another example will occur to most of us: days on which, without anything to indicate any special drive or any special resistance, we have been quite at sea as to what is going on. This is, of course, a common experience, and I mention it here with the idea of commenting later on our attitude to such manifestations. There are many other examples of unobtrusive resistance: constant preoccupation with emotional material which on examination is found rarely to have much direct connection with the patient's *own* experience, vicarious sacrifice through the mechanism of introjection. Another is an imperceptible deflection of libido to non-analytical objects, a deflection which is not selective, but rather in the nature of an undifferentiated spread outwards and away from the analytic situation. As a last and simplest example of unobtrusive resistance, we may advance the phenomenon of unswerving punctuality at analysis. But the isolation and clinical description of forms of resistance is really not very satisfactory: it ignores their inter-relations and gives no clue to the actual state of the analytic situation. For example, many of these 'doldrum' periods may be closely related with some change in extra-analytical libido-dispositions or some shifting emphasis in the symptom-picture, either or both of which may have gone unnoticed. Again, what seems to be a very stormy resistance may be actually a prelude to the weakening of defences. So we may go on to consider the next aspect of the problem, namely, the *functional* aspect.

I do not propose to spend much time on the general mechanisms of defence. These are exhaustively described in almost every text-book of psycho-analysis. Until recently it would have been sufficient to say that any of the processes described as being part of 'repression' were *à priori* resistance-mechanisms. Resistance was evidence of the operation of repression. But, as we know, the term 'repression' was quite unable to contain all the elements of mental defence and latterly was employed so loosely that Freud found himself compelled to re-employ his older label, viz. '*defence*'. Repression was then shorn of its bulk and became, along with reaction-formation, regression, etc., one of the mechanisms of defence. But it is still true to say that each and all of the mechanisms of defence can function as resistance. Now I need not give a catalogue of processes like projection, displacement, distortion, rationalization, of reversal or reaction-formation, counter-charge or screening, of amnesia and so forth. That is a matter for systematic study. But I wish to advance this functional stand-

point in order to avoid a possible misconception of the nature of resistance. In talking of ' resistance phases ', ' periods of resistance ', ' overcoming resistances ', I may have given the impression that defensive processes are simply artefacts, peculiar to analysis. This would not seem to tally with the accepted generalization that defences exist throughout the whole of the analysis. I think the functional view avoids any confusion. It is true to say that there is something characteristic in the nature of the defences evolved by analysis, certainly from the quantitative point of view (that is, their intensity), but it is equally true that the mechanisms of defence have not been newly formed to meet analytical junctures. This is what is meant when writers on technique tell us that the unconscious or, as we should now prefer to call it, the id, is everywhere. The id—the source of instinctual energy—is, in the sense of continuous drive, everywhere and always. As a concession to reality it has, we might say, grown the ego, or more accurately it has, at its external boundary, been modified into a reality-organ, the ego ; and that organ to some degree or other functions, no matter how slightly, for the ' always ' of the individual, i.e. during his existence. So that defences are always present, as in the dreams of the dying. If this were a theoretical discussion, we could now proceed to consider the regulation of instinct by the pleasure and reality principles. But I prefer to keep to the practical implications of the functional point of view. As, however, we have mentioned the modification of instinct, we may well illustrate the functioning of resistance by means of an appropriate example, i.e. the cover afforded to unmodified drives by the existence of modified tendencies, in other words by sublimation.

Now, if you will allow me, I will refrain from entering into a theoretical discussion of sublimation. I think we are on safe ground if we go on the customary definition that it represents that modification of a sexual impulse by which it is divested of its sexual aim and is turned into other channels, the whole process being effected unconsciously. In the process of deflection the mechanisms of identification and displacement are employed, so that when we come to examine a sublimation it is rarely difficult to see at what point in infantile development the deflection was initiated or the possibility of side-tracking established. Now it will be agreed that various cultural activities of mankind, both creative and imitative, constitute true sublimations in the sense of our definition. Turning for the moment to observations of another kind, it is general experience that snobbery of various sorts is

to be taken as either a positive or a reactive indication of a set of superiority and inferiority values, which, on further examination, can be related to the infantile family setting. We might say that from one point of view snobbery represents a scale of castration values, set up by the ego in accordance with stereotyped libido-dispositions and sensitiveness to anxiety. It cannot have escaped attention that in most analyses questions of cultural development and appreciation appear to be very highly charged with anxiety. Patients behave as if their mental perfections were about to be put to the test of nakedness ; and, moreover, they are found to be critical of the æsthetic taste and qualifications of others, particularly, as Abraham long ago emphasized, of the analyst's real or imagined æsthetic imperfections. Now the point about this type of resistance is that, where such a position is strongly maintained, a large part of castration affect might escape our notice. It may occur to you that I have chosen a needlessly complicated example to illustrate this functional aspect ; and it is true that a simpler example might have been found. We might for instance have taken the case of projective types of defence and have shown how they operate normally and continue to operate during analysis in a more striking fashion. My reason for choosing the ' cultural anxiety ' example was to draw attention to the *high defence-value of rationalization.* Rationalization is of course a very broad term and is capable of much sub-division, but, generally speaking, it is distinguished from pure repression in that the excitation in the case of repression is kept at a distance, whereas rationalization is a *screening* process, intended to cover a flaw in repression, e.g. to cover ideas or actions which are intended to gratify an unconscious need. Rationalizations are, however, of special importance in analysis, because we tend to reject them automatically where we conclude that the attendant affect is disproportionate and, *what is much more questionable,* tend to accept them on their reality-value when we think the reaction is adequate. This is a problem of great importance during the analysis of the transference-neurosis, and we shall consider it in more detail later. To continue with the functional analysis of this cultural resistance, we have to note that it is screened by preoccupation with sublimations. Now sublimation is itself primarily a defence of the ego against unmodified instinctual drives or alternatively against the dangers apprehended should such unmodified drives be gratified. What happens in our case is, I imagine, that the id attempts to undo the effect of this sublimation to a certain extent by a process of infiltra-

tion, and the rationalization is simply a reassurance to hoodwink the super-ego, as if to say, ' Don't ferret around here for id-gratification, this is all genuine sublimation '. We see then that every form of instinctual modification can be made use of for defensive purposes and that the ego is constantly engaged in keeping a balance between defence and counter-attack, trying to make the best of things.

This principle of balance of advantages is, however, a useful introduction to the third avenue of approach to resistance problems, viz. the *transference-resistances*. Here we have a highly specialized ego-defence, in which an attempt is made to avoid the uncovering of unconscious ideas by their re-enactment in analysis and in relation to the analyst. Moreover it represents an attempt to snatch real libidinal gain, as it were, on the run. The example of this relationship most frequently described is that where a patient's resistance has to be considered as part of his negative transference and so related to the kernel of his infantile emotional dispositions, the Œdipus complex. In this sense many resistances can be related to the castration situation and represent a repetition in relation to the analyst of the positive or inverted Œdipus complex as the case may be. This represents in fact one of the most difficult phases of analysis, but if we come to consider it in greater detail it will be seen that it is an inevitable phase—indeed that, provided we can keep control of the situation, it is one to be welcomed. Let us consider what leads up to this situation. A few moments ago we were asking whether there was not something specific in the resistances to analysis, and I suggested first of all a quantitative factor as being characteristic. But there is another factor which distinguishes analytic resistances from the mental defences in all other situations : it is the revival, re-animation, re-experience in analysis of the incest-wish and the incest-barrier. Not the toleration of conscious incest-wishes of an adult variety, a type of sexual wish frequently met with and frequently gratified, but the conscious conviction through mental experience of the reality of the infantile Œdipus situation in all its strength and horror. This can occur nowhere else in human experience. Now we know that, through the process of identification, analysis is equated not only with simple situations of the nursery type, e.g. excretory rituals, but with purely unconscious situations such as that of apprehended castration. All patients expect to lose something valuable in analysis and many show from the beginning what the unconscious view of the situation is : a patient dreams on the second day of analysis that he has just climbed a rickety

scaffold, apprehends execution and begins to beat a speedy retreat, saying in an expostulatory manner,' Look here, I must be getting down out of this or there'll be trouble '. So that from the very beginning we should expect to find that a defensive process expressed in terms of analysis would be equated with a legitimate defence against mutilation. When the homicidal paranoiac shoots someone who he thinks has dark designs on his potency, to be effected by means of injections or electrical discharges or other malignant influences, we can appreciate his point of view, but regret his defective sense of reality. In the analytic situation we may sometimes regret that the neurotic or alleged normal type has not some of the paranoiac's insight into the equation of treatment and mutilation, or even if, as occasionally occurs, he has insight, that it is insight of an intellectual sort, desiccated of emotion. Indeed, we may recall here as confirmatory evidence of our views that in some reported cases of analytical resistances (cf. Alexander) temporary attitudes of a paranoidal type have been observed. Moreover it is probable that in some extreme cases of transference passion the erotomaniac attitude developed is a defence of the same group.

But in addition to the fact that the analytic situation is equated with the Œdipus situation from the outset, we must remember that we have been from the very beginning taking every step possible to see that we lose none of the affective charge appropriate to this situation. You will note of course that I am here compelled to make reference to stages in analysis. At the beginning we enforced a rule of free association ; we encouraged the expression of preconscious representations of unconscious wishes ; we were on the outlook for all sorts of mechanisms of displacement and projection : we reversed these mechanisms in order to drive out from every hiding-hole affective charges which we wished to assemble on the analytic field. If they exploded on the way, we pointed out their direction ; if they were too explosive, we were content with a sample. We cannot therefore be surprised if, at the end of a few months, the analysis becomes charged with affect and tends to take on an increasingly infantile colour. Every time we reversed a projection we did not necessarily annul it : the patient said silently ' Oh very well, if I can't project it there, what about projecting it on to you ' (the analyst) ?

But yet another specific factor has been at work. In bringing up his material the patient has inevitably touched upon matters, and exhibited reactions, which are reminiscent of his pregenital stages of

development, his reactions to thwarting at oral, anal and phallic stages, with their various types of sadistic accompaniment. He has revived attitudes of criticism which were once appropriate to the nursery, e.g. the strange inconsistency of parents in their seemingly hypocritical intolerance of childish activities which they themselves clearly exploited. So that when we begin to analyse in an adult various critical attitudes to significant personages outside analysis, various tendencies to see the feet of clay, we are laying up a lively charge of analytical criticism for ourselves, in other words, courting a negative transference. Now quite apart from the fact that we prevent overcharge by various amounts of interpretation as we go along, the patient, too, is attempting to deal with overcharge, but with a significant difference in aim. He is showing perfectly normal function in the endeavour to bind this charge, but he is anxious to get it bound before there is any chance of opening up the original channels of communication and bringing the charge home to its infantile roots. So he binds it, *if he can*, in analysis. From this point of view the strength of the transference-wishes is comprehensible. It is not for our intrinsic virtues that patients adopt an amiable attitude of appreciation towards us: they are defensively endeavouring to make puppets of us, to ' buy us off ' before the matter goes any farther. In the same way it is not for our inadequate personalities that they castigate us, revile us, and in certain instances cast us out. It is an eleventh-hour attempt to bind not only their hate but their thwarted love. And not only their thwarted love, but a certain kind of unthwarted love: for we know that in at least one pre-phallic stage of development, to beat is to love, as indeed the sadist and masochist still think. Hence almost literally they endeavour to beat us in both analytic senses of the term or to rouse us to reprisal. Obsessional cases, with their anal-sadistic fixations, exhibit this in a characteristic way. In the opening phase they may in fact have recalled that as children they were violently excited and enraged by the administration of enemata; they may have informed us (although this is not so likely in the first stage) that they are still preoccupied with exciting phantasies of the ' enema ' or ' whipping ' group. We might, after elaboration of these subjects, come to the conclusion that we had ' analysed ' this part of their development. If we did, we should in most cases be wrong. We should have missed entirely the defensive transference repetition of these phantasies. Casting back, we should remember that on many occasions they had asked us with (as we now see) mock solicitude,

whether they were doing things ' in the right way ', that their association habit was to pretend to tell us something but always to deny us at the last minute. They may even have confessed to the idea that we have been aggravated by their conduct. In short, they are ready to be informed as a prelude to deeper interpretation that their phantasy is one of being ' whipped ' or ' clystered ' by the analyst. But, in the first instance at any rate, all we could say about them was that judging from their association and demeanour, they ' resisted ' analysis. Here we must leave the subject of transference-defence for the moment, to return to it when considering the stage of ' transference-neurosis '. But before doing so, we may repeat in general terms that both positive and negative transferences are made use of for the purpose of defence.

We have, however, in considering the transference aspect been preparing the way for the fourth line of approach, a *consideration of resistances in relation to fixation-points* in development and to the choice of disease, the option of neurosis. We need not spend much time on fixation-points, not because they are unimportant, but because their influence on analytic associations and attitudes is not difficult to recognize. Of the many observations we make during the opening of analysis without necessarily communicating them at once to the patient, different types of association and different attitudes to objects and activities come easily first. One thinks at once of typical anal reactions and attitudes, the tempo of associations, the attitude of grudge or reluctance to part with them, the nursing of ideas, the impulse to give a complete or rounded narrative, the resentment of interruption, the rejection of interpretation, sensitiveness to changes in time, reactions to the payment of accounts, and so on. Similarly we find in the patient's extra-analytical reactions evidence of the same attitude in relation to all external objects or again in his attitude to activities, professions or professional hierarchies, to authority, to underlings, etc. But, you may legitimately ask, do you not analyse all these as they appear ? what do you mean by not communicating them ? Now of course we do analyse or rather ventilate many of these attitudes immediately and, it may be, quite early in analysis ; not necessarily all, however—otherwise we might get side-tracked or teach our patients how to side-track themselves. But at the beginning our purpose is to ventilate everything that is a stumbling-block to the progress of the analysis. What we do keep to ourselves for the time being is an increasing conviction of the significance of certain stages of development. *The time to ventilate this most effectively is when, in the*

reconstruction phases of the transference-neurosis, we are able to give actual point to our earlier generalizations and impressions. To give an example, in the analysis of a slip or attitude which had some clear anal significance, I should be satisfied in the earlier stages if, as the result of my interference, the patient brought up an earlier set of reactions of a similar kind or, better still, if he recalled nursery memories of unimpeachable intensity. In the second phase I should want to know first where I came in, i.e. what the transference-significance was, and if the time was ripe I should endeavour to correlate this with previous interpretation, *always provided I could add a little point to a previous comment.* If at first we get side-tracked in proving to the patient that he is a thoroughly anal type, we may not only arouse his later legitimate defences at an earlier stage, but may provoke the question ' What of it ? ' before we are actually able to correlate our findings. Coming back to evidences of fixation as they appear in resistance form, we must again refrain from giving a mere catalogue of the different types. These can be got from general reading and are not difficult to classify. The same may be said of analytic reactions which throw light on the original strength of the component sexual impulses. We may note, however, as in the case previously mentioned, how one group may screen the other, how the type of patient with anal preoccupations may really be gratifying an otherwise inhibited exhibitionist tendency. In both groups the main classification is one of positive types and inhibited types.

Now to consider types of resistance characteristic of different disorders : I wish to make only the barest reference to these here, because the subject will occupy our attention more fully later, when we are considering different forms of the ' transference-neurosis '. This is, however, a suitable moment for reminding ourselves that, in Freud's latest work (*Hemmung, Symptom u. Angst*), not only have mental defences been given a more orderly classification, but that they have been roughly correlated with different stages of development, and consequently with the disorders attendant on fixation at these stages. Put very simply, perhaps too simply, the position is as follows : Freud in examining the problem of anxiety came to the conclusion that anxiety is a *danger-signal* given by the ego as a warning against the danger of approach of a state of psychic helplessness in the face of overwhelming stimulation ; it is a sort of sample-reminiscence of a previous helplessness as experienced at birth. In considering what might represent a danger of helplessness, he concluded

that this would be modified in different stages of development, and he correlated these modifications with different clinical conditions, e.g. fear of the loss of the protecting and gratifying object with early infantile phobias, castration-fear with later phobias, fear of loss of love with hysteria and fear of loss of love by the super-ego with obsessional neurosis. Then, taking up the question of defence, he suggested that repression is a process having a special affinity for the genital organization, and is therefore the characteristic mechanism in hysteria ; in the case of the obsessional neurosis he points out how regression to an earlier stage of libido-development is used as a defence. Further, in regard to reaction-formation, he shows how in obsessional neurosis this is directed against inner stimuli, i.e. the strength of instinct-excitation, whereas in hysteria the counter-charge is directed mainly towards external stimuli calculated to excite inner excitation. Finally, in the case of the obsessional neurosis he describes mechanisms of ' isolation ' and ' undoing ' which operate with a view to surrounding any impulse-presentation with a thought- or action-vacuum. The description I have given is extremely inadequate, and it is not to be supposed that there is any hard and fast separation to be observed in any one case. But these general indications can, I think, be turned to advantage during the analysis of resistances. They explain, for example, the necessity which the hysteric shows for feverish retention of an inflamed transference-situation and make us understand one of the reasons why the analysis of the transference is so vigorously resisted in spite of its extremely obvious manifestations : the patient is struggling to avoid a traumatic situation implied in transference-dissolution. Hence, for purposes of reassurance, it is necessary to feel that the analyst really loves him or her. Moreover, it is doubly necessary for the patient to keep alive transference-passion in order that this may cover hate-tendencies by hysterical reaction-formation. Further, we can understand why the phobia patient tends to behave in analysis as if he were in imminent danger of castration at the hands of the analyst. Freud's views show us that much of our work in the obsessional neurosis will be the reversing of reaction-formations, retracing the course of regression and placing thought-bridges over the defensive vacuum-belts ; again, that we must not be deluded in obsessional cases by the fact that the presentations are not repressed, although much distorted ; that we have still to make such patients as affective in thinking as the hysteric is affective when his repressed ideas are uncovered. Moreover, we can understand why even the

slightest ventilation of phantasy in obsessional neurosis is heralded by an interminable string of apologies made ostensibly to the analyst, but actually produced for home-consumption. The patient is placating his super-ego.

So far our approach to the problem has been systematic, a general description of clinical appearances, function and relation to stages of development. But we must not lose sight of the fact that in actual analysis the problem has an essentially practical side. *When we stand back from analysis we can visualize the defensive function of resistance ; but when we are actually engaged in analysis the outstanding fact is that the patient's own personality is the mouth-piece through which these defences are expressed.* In short, the general impression given is that the patient is *personally* resisting, instead of being the tool of his unconscious mechanisms. This does not apply so much to the difficulties arising at the very beginning of analysis, where he seems to be ' doing his best ' ; in the last lecture I offered as a tentative explanation the possibility that these were mainly super-ego resistances associated with guilt-feeling. But I also suggested that the next batch had a different origin, were typical ego-resistances. Now, when these general ego-resistances gradually shade off into specialised transference-resistances, they are apt to create an impression of ' perversity ' in the sense in which a child may exhibit an ingeniously perverse disposition. Now it is partly true to say that sooner or later the patient behaves like a perverse child, and there is no objection to this description provided we keep in mind that a perverse child is a child already on the defensive against instinctual urges. It is of course inevitable that as the analysis proceeds and infantile development is unfolded, either directly or indirectly, the analytic situation will take on the colour of an infantile situation and the patient will behave at times precisely like a thwarted child. He may experience the impulse to yell and scream, to throw things about, to gnash his teeth, to say ' Shan't ' when encouraged to associate. He may in fact carry many of these impulses into action. All of these are typical transference-repetitions of a regressive type, and usually disappear after interpretation of the situation in relation to infantile development. They may recur, but can once more be reduced. Sooner or later, however, we find that some situations cannot be reduced in this way. Situations of mistrust, injury, grievance, depreciation, etc., often dramatically represented in the transference, may begin to dominate the analysis for the time being. We give what seems a valid

interpretation, but the effect seems to be either minimal or transient or entirely nil. The same or similar material comes back seemingly just as highly charged, and the defensive reactions are as vigorous as ever. We repeat our interpretation, possibly from a new angle, but again the result is the same. The process is repeated over a prolonged period, until we begin to think that we are dealing with a transference manifestation of *obstinacy*. But we find that even repeated interpretation of the situation on the basis of negative transference does not seem to make much difference. We think of some concealed exhibitionistic satisfaction, but interpretation along this line does not materially alter the situation. In short, having exhausted the possibilities of resistance arising from the ego or the super-ego, we are faced with the bare fact that a set of presentations is being repeated before us again and again. That is at the same time a clue to the understanding of the situation, because the nearer we get to seemingly blind repetition, the nearer we are to a characteristic of instinctual excitation. It seems then that the id has turned the tables on us. We expected that by removing the ego-resistances to an idea we should bring about something like automatic release of pressure, that the charge would either dissipate itself explosively and openly, or that some other manifestation of defence would immediately arise to bind the freed energy, as happens in transitory symptom-formation. Instead of that we seem to have given a fillip to the repetition-compulsion, and the id has made use of weakened ego-defences to exercise an increased attraction on preconscious presentations, an attraction the existence of which is of course already familiar to us in observing unconscious drift during free association. For this reason Freud has described the manifestation as being the '*resistance of the id*'. He had already told us that during analysis there are certain situations which cannot be immediately resolved by mere interpretation, but require a process of more or less prolonged '*working through*'. This process of 'working through' is now recognized as the only method at our disposal with which to counter the id-resistance. The id, having no organization, cannot be affected save through the presentations it charges and the affects it initiates: that is to say, we can only deal with it *via* its boundary-formation, the ego.

At this point you will doubtless recall that earlier in the discussion I described certain 'doldrum' periods in analysis, describing them generally as being at first unobtrusive and relating some of them more specifically to exhibitionistic tendencies, manifestations of trans-

ference, etc. I was careful, however, to add the saving clause ' where there is no *bonâ fide* evidence of " working through " '. The reason is now apparent. If we are certain that the defences in operation are ego-defences, we may expect to obtain some result by directing attention specifically in these directions, but if the ' doldrum ' is due to id-resistance, continuous hammering at the ego, on the grounds of vague feeling that we are dealing with transference perversity, is not likely to produce any result, and may in addition give the patient an impression of perversity on our part. Hence I have left the question of ' working through ' almost to the last in order to correct the impression of personal motivation in resistances. It has to be admitted that the existence of id-resistances is generally arrived at by a process of exclusion, and in practice it is safer to do so : we are less liable in this way to overlook unobtrusive ego-resistance. For the rest, we must depend on our feeling and judgement as sharpened by experience. I have remarked elsewhere that there is an absorption-point for all kinds of interpretation, to go beyond which is unnecessary and sometimes inadvisable. This is true of local resistances and especially true of larger movements of resistance. *When we have found that a repeated interpretation has no effect, the first thing to do is to consider whether it is valid or covers the ground sufficiently, and the second is to look round the analytic situation and the patient's external situation for possible oversights and omissions. During this process we need not press interpretation any farther : we must wait until we have more information to go on. In the meanwhile the patient will have a needed respite, during which he will continue the process of ' working through '.* In the opening lecture I advised against taking a too schematic view of analytic situations and phases : I should like to supplement this here by saying that *analysis is not to be measured by numbers of sessions.* One occasionally hears the comment ' I got nothing out of so-and-so to-day or last week or last month ', or again, ' We seem to be stuck for the moment ', or ' I felt that I had not earned my fee on such and such a day '. We shall see later that this is mainly a manifestation of guilt or anxiety on the analyst's part, but in any case it is unnecessary self-reproach in view of the nature of id-resistance.

One final example of resistance requires special mention in our review. It is the resistance due to the disturbing effect of analysis on the ' gain through illness '. I need not take up your time with the distinction between primary and secondary gain ; nor need I give any detailed clinical illustrations of these differences. Psycho-analytic

literature is full of dramatic case-histories illustrating the operation of ' gain through illness '. I would merely point out that the operation of ' gain ' mechanisms can be observed very clearly at two points in every analysis. The first is when in the course of developing transference the patient can afford to abandon some of his symptoms. At this stage we can often observe an attempt to strike a new bargain and can judge from the nature and urgency of transference demands the libidinal and ego value of the earlier construction. We may for example have inferred from the nature of the symptoms accompanying a depressed state that they represent a distorted and inverted sadistic phantasy. Striking confirmation of the accuracy of our impression can often be observed during phases of remission. The patient may make quite overt demands on the analyst for the satisfaction of active or passive sadistic impulses, and react to the absence of gratification by a resumption of symptomatic expression, a resumption which, by the way, should be countered as far as possible by interpretation of the gain mechanism. The second opportunity occurs towards the end of the analysis, when the patient, apprehending loss of the transference situation or finally realizing that transference demands are barren of fulfilment, in fact incapable of it, endeavours to fall ill once more. Actual observations of this sort will do more to convince you of the defensive value of ' gain ' than a good deal of case-reading in the literature.

We are now in a position to summarize our views of resistance and to give Freud's classification of them into five groups in accordance with their origin. First of all, the *ego* uses the customary defence-resistances against id-excitations in order to keep unconscious presentations from consciousness in analysis. *These are repression or defence-resistances.*

Secondly, we have the *transference-resistances*, which endeavour to avoid memory work by keeping alive a new enactment of old situations in the transference.

The third is the *resistance due to the gain through illness*, which is connected with the ego's manipulation of symptoms. *All these are ego-resistances.*

The fourth is the type we have described where *guilt-feeling* and *self-punishment* tendencies indicate a conflict between the super-ego and the ego. This is the characteristic of *super-ego resistance*, sometimes called the ' negative therapeutic reaction ', when the need for punishment continues to exploit symptom-formations and is the sole remaining barrier to their resolution.

The fifth is the *resistance of the id*, which is indicated in the process of '*working through*'.

To relate these now to analysis, we may say that the first group, defence-resistances, functions throughout analysis with periodic fluctuations in activity. As a rule they catch our eye first, and are therefore perhaps a little too optimistically regarded as being mainly associated with the opening phase. Transference is, as I have said, always present, but the transference-neurosis is so characteristic that it has been given a special stage by itself. Transference-resistances, especially in the form of manifestations of negative feeling, are seen throughout this stage, and again when we attempt to dissolve the transference. Gain-resistances are most apparent at the commencement of the transference-neurosis and in the last phase of analysis. Super-ego resistance is constantly operative, but may give rise to especial difficulty at the beginning of analysis and again in the later stages of the transference-neurosis. On the one hand, owing to the punishment value of symptom formation, super-ego resistance holds up the transference resolution of symptoms, i.e. it prevents a full expansion of transference. On the other hand, it seeks to maintain whatever element of projection is already established in the transference, i.e. it hinders resolution of the transference. When these two factors are accentuated we are faced with a hold-up which is only comparable with id resistance. The latter, like super-ego resistance, is always operative, but is most obvious in the second half of analysis.

We have here the key to the vexed question of dealing with resistances. We are in constant conflict with functional ego resistances and we can safely deal with these as they arise, remembering of course that repression is a means of preventing anxiety. Transference-resistances have to be commented on as they arise, but we can make best use of them when, by memory-work or reconstruction during the transference neurosis, we seek to uncover the patient's forgotten development. Gain-resistances are uncovered along with transference-resistances, but are finally uncovered in the regression stages during the last phase of analysis. Super-ego resistances have to be explained early in many cases, but cannot be effectively uncovered apart from the transference. Given sufficient attention to other sources, id-resistances must be given their own time.

IV

COUNTER-TRANSFERENCE AND RESISTANCE

During our consideration of the opening phases of analysis and of the varieties of defence which may be opposed to this process, we have gone on the assumption that the analytical sauce was all for the analytical goose. We have for convenience in presentation taken for granted that any difficulties arising were due to mechanisms of defence exhibited by the patient. This is a comfortable but inadequate assumption, and I do not imagine we can go on profitably with a description of the next phase in analysis without some precautionary consideration of the analyst's own position. We have to remember that this next phase is roughly that of the ' transference-neurosis ' proper, a stage where the history of the patient's development leading up to the infantile neurosis will be re-enacted within the analytic room. During this period the patient plays the part of actor-manager, pressing into his service, like the child in the nursery, all the stage properties the analytic room contains, first and foremost the analyst himself. The latter, like the repertory actor, is cast for various rôles, only a few of which, if undertaken, would be gratifying to his vanity ; the patient, childlike, tends to project on to the analyst the more displeasing and distasteful parts. The situation is similar to that which obtains in dream-life where apparently distinct personages play at one time the part of object and at another the part of subject in the patient's phantasy.

There is, however, an essential difference between the play-acting in dreams and the play-acting which goes on during the transference-neurosis. It is a difference in the reaction not only of the patient to his dream-material, but of the analyst to whom the dream-material is imparted. It requires little experience to learn that many patients rather enjoy analysis of dreams, even where the content is seemingly distasteful. It is after all ' only a dream ', something for which the patient does not hold himself personally responsible, thereby affording respite from the recital of other affective material. He is prepared during positive phases to be interested or co-operative in dream interpretation as if the process were a complicated but rather intriguing parlour-game. In negative phases, his co-operation will take the form of attempting to displace the analyst, vying with the latter in disinterested interpretation, or presenting what he considers to be more valid and ingenious explanations.

The analyst is not likely to remain hoodwinked by this enthusiasm on the part of the patient, but it is just possible that for some time he might not observe signs of reaction on his own part to dream-material. For example, during an otherwise obscure period in the analysis he may find himself glad to seize upon a dream-fragment in the hope of illuminating the immediate difficulty. This is a perfectly reasonable, legitimate and every-day procedure. But we are not engaged for the moment with the technical aspect of the situation: what concerns us much more is the reaction of *relief* experienced by the analyst, indicating as it does that he has been worried by the apparent lack of movement in the analytic situation. In other words, his attitude to this particular fragment of analytic material has been partly reinforced by reason of subjective tension. But suppose now that the analytic situation had not been obscure, that the analytic picture had been dominated by a negative transference, and that the patient's querulous or nagging criticism had been punctuated by fragments of dream-material. Here any tendency to preoccupy oneself with the dream-material to the exclusion of a pressing transference re-enactment would merit a certain amount of self-inspection, on the grounds that the seemingly impersonal nature of dream-production may afford the analyst the same respite from unpleasantness as it does the patient. It is easy to see oneself playing the alternate parts of hero or villain so long as there is no doubt of the element of ' make-believe ', but in the transference re-enactments the actor-manager (the patient) is unaware that there is any make-believe. Just as he is consciously quite sincere in his arrogation of the ego-syntonic parts, so he is quite convinced that his projection on to the analyst of ego-dystonic rôles is simply a description of fact. For prolonged periods the analyst will find himself regarded by the patient as the living personification of qualities and attitudes repugnant to his own ideal.

Now, without recapitulating the considerations concerning the perfectly analysed analyst mentioned in the opening lecture, we may remind ourselves that the id is always with us and that, however happily instinctual drives are sublimated in the profession of psycho-analysis, it is also a function of the mind to deal with current stimulation and reduce its intensity. If we go further and assume that the stimuli occurring during analytic practice are of a highly selective sort, battering against a newly established protective system in the analyst's mind, it is not unreasonable to suggest that this protective system should be kept in constant repair. It is not difficult to see that a

situation of this sort is bound to arise. Consider, for example, the mechanism of projection which is so constantly exploited by patients in analysis. Projection is a return to or persistence of the old system in infancy whereby an inner pleasure-ego is kept free from inner pain-elements by projecting the latter into an outer ' painful ' world. So the patient, whenever possible, projects his ' painful ' ideas : e.g. it is not he who is inferior or who deserves punishment for entertaining guilty ideas ; it is the analyst who is a fool or who deserves to be exposed. The patient has thus endeavoured to purge his inner pleasure-world of painful ideas and has aimed the rejected products with considerable skill at the personality of the analyst. But his aim is more accurate than he knows. His analyst has gone through the same ego-development, has used qualitatively identical mechanisms of defence, and has in his day projected literally to his heart's content. But, it will be remarked, he has since been analysed, and ideas of a stimulating kind will no longer act selectively on his mind. So much may be admitted freely : if the analyst's analysis has been successful he will not be *hypersensitized* to products of his patients' unconscious phantasy. Neither will he be in the strict sense of the term *immune*, a state which really implies a defensive familiarity. He will be able to translate these products *without reacting to them*. But listening to a phantasy, or to the description of external happenings in which the analyst is not directly involved, is a different state of affairs from having to see oneself in the patient's mind playing all sorts of *real* and inferior parts in relation to him. This is in a way an attack on one's ego. Now of course in the castration sense one ought to be free from the tendency to take umbrage or to counter-attack, but it seems to me that here is a type of stimulating situation which cannot be avoided in analysis and must be met as a current source of tension. And of course there are many other ways in which a stimulating situation may arise. After all, the mere fact that any one case does not automatically recover is an aspersion on the analyst which for a time may go far to outweigh the positive sublimatory satisfactions of the analyst's profession.

At this point we might be led into an interminable discussion of the subjective influences which may be held to be permanently resolved by the analyst's analysis and those which are liable to act as current stimuli irrespective of analysis. For example, a refractory case may prove a source of stimulation because the patient's attitude runs counter to the analyst's desire to heal, i.e. to his sublimations ; or it

may do so because the analyst's omnipotence attitude has never been fully ventilated, or because his oral and urinary erotic tendencies still demand satisfaction and evidence this through the characteristic trait of impatience on being thwarted. As it happens, there is no necessity to embark on this discussion, and for many practical reasons. Freud has pointed out in regard to neurotic formations that it is not so much the qualitative factor as the quantitative factor, the amount of interest charging a presentation, which may determine its pathogenicity. The fact that the analyst in his extra-analytical life is subjected to the ordinary stresses and strains of ego and libido adjustment makes it at any rate conceivable that the amount of satisfaction obtained from work which occupies a large proportion of his daily time and absorbs much of his energy must represent an important item in the current balance-sheet of mental tensions. Now both of these factors, i.e. extra-analytical and analytical satisfaction, are variable : hence, even if we make the greatest allowance for a hypothetical state of being ' thoroughly analysed ', it is evident that at the least some analytical ' toilet ' is a part of the analyst's necessary routine, in order to keep the balance redressed.

I think we need not spend any time in stating the case of counter-transference. What applies to the reactions provoked by transference projections applies equally to the result of positive identifications. Here the analyst is endowed with characteristics, many of which, e.g. tolerance, impartiality, etc., are quite definitely part of his own conscious ideal system. It is easy to see that patients whose attitude is strongly ambivalent will, by rapid alternation from extreme positive to extreme negative reactions to the analyst, put the latter's psychological integrity to the test. Nor need we consider the more narcissistic factors which have to be allowed for in the practice of analysis. As Freud has pointed out, the analyst's habit of sitting out of the patient's view serves two purposes : it is essential to the maintenance of that impersonality which in turn makes transference-interpretation more convincing, but it also protects the analyst from the strain of being under continuous purposive scrutiny during the whole of his working day.

Assuming now the possibility of subjective influence under certain special circumstances, how are we to detect this ? What are the indications or danger-signals ? The probability is that these will be found to have some resemblance to the general indications of resistance in any analytic situation, and at the same time to have some dis-

tinctive features related to the specialized nature of the analyst's activities. Hence to obtain any satisfactory answer to our question we must review the various phases of individual development and consider how far these may influence analytic attitudes.

Before embarking on this review, it may be well to consider how far such systematized reviews are valid in general analytical work. It may have occurred to you that instead of dealing with general movements in analysis it would have been more useful to devote these lectures to a systematic account of stages in individual development together with some indication of the particular manifestations they produce in analysis. It has to be admitted that there are many occasions in analysis when the material produced is extremely complicated in texture : every analyst must have experienced a difficulty in ' placing ' his material and have longed for an infallible sense of orientation. Can this be produced by cultivating the habit of reviewing associations and reactions in terms of stages of development ? I think the answer is that, whilst a sense of analytical perspective must be cultivated on a solid ground of systematized information, it can also be considerably hampered by over-anxious clinging to a structural point of view. Should the analyst follow this latter course too exclusively he may find that instead of analysing his patient, at some given moment, he has simply been engaged in a process of scientific description. He may, for example, fall back on his own knowledge of processes of development and classify his patient's material, noting for instance the presence of oral, anal or phallic imagery. His classification may be quite accurate, but it is of itself unimportant. It is true we want to know what particular group of ideas is in process of ventilation, but we must understand not only where this particular set fits into the patient's scheme of development but its relation to other groups. In other words, how much of the patient's early history can we *reconstruct* from his reactions, how has one phase modified another, and what processes of acceleration, retardation or regression have occurred. Even then we have by no means exhausted the situation ; we must be in a position to realize the immediate significance of any drift in association or of any set of specific reactions, e.g. whether it has any immediate defensive function. When an obsessional case constantly insists on making involved explanations, ostensibly embarked on ' to make things clear,' and at the same time hates to leave a subject ' in the air ' and must ' round it off ', we may reasonably regard this as evidence of an accentuated infantile anal characteristic, one which

is being exploited in the interests of his analytic resistances. Incidentally, when the analyst experiences a similar compulsion, e.g. to do a neat bit of work each day, to round off each analytic session with a complete explanation, we may suspect a similar interest. Having made interpretative use of our observations, we then add them to the store of information we are gradually accumulating concerning the relative importance of different stages in the patient's development. We do so not simply for scientific interest, but in the hope of being able ultimately to determine fixation-points or to measure regressions. As we shall see later, it is sometimes a matter of great difficulty to determine whether an interest is regressive or due to fixation, and we must often search collateral sources of information, e.g. the symptom picture, for the answer. Even there it is largely a matter of scientific interest when we are able to say ' so-and-so has an oral (or anal) fixation ', and for any therapeutic purpose it is useless to inform the patient of this fact. The importance of recognizing a fixation is related solely to our own grasp of the effect such a fixation would have on the patient's subsequent development. It is not in itself important that so-and-so has an oral fixation, but it is important that owing to his oral fixation a sadistic component in his object-relations has become pathogenic. To come back to our immediate concern: reviews constitute a useful analytic exercise and assist us in ' placing ' certain analytic material and in arriving at diagnostic conclusions, but they are not a substitute for analytic interpretation. I imagine that the tendency to accuse patients of fixations belongs to the classical signs of counter-resistance. With this preamble we may proceed to do for the analyst what we have not been able to do for the patient, consider in a systematic way how far his individual development can be reflected in his analytic attitudes.

If we start from the most primitive layers of ego-organization and libido-development, we are immediately faced on the one hand with various omnipotence-attitudes on the part of the ego and on the other with a reaction to immediate ' getting ' which is characteristic of the oral organization. You will remember that Jones in his study of the ' God-complex ' pointed out the satisfaction of primitive ego-attitudes which is sought for by the psychologist. That a patient should presume not to get better is an offence against the majesty of every therapist, for which the mildest appropriate punishment would seem to be excommunication or banishment. Indeed, it is no uncommon thing for the family doctor or consultant or general psychotherapist

to gratify this revenge-impulse by recommending a ' change ' or a ' sea voyage '. For the analyst there is no such compensation; all he may do is to take stock of his own omnipotence. Now with regard to oral impulses, these can be early observed in many of the *patient's* reactions to the analytic situation and to association. This applies not only to his own flow of words and ideas, but to the interpretations of the analyst, which he regards as a kind of suck to be demanded in constantly increasing quantities. There seems to be no doubt that the analyst, for his part, may have similar difficulties. One of the besetting problems in analysis is when to speak and when to be silent: another, how much or how little to say. There is, as you can imagine, a positive tendency in the direction of giving too ample suck: here one at the same time identifies oneself primarily with the mother, and one's patient with oneself as a child. There is also a possible negative tendency, to be sparing of suck, one which is liable to be reinforced by influences related to anal development. Here is a situation where one is at the same time a parent and a successful but revengeful rival. But what if the patient takes a hand and refuses to give *us* the optimum amount of associative pabulum or attempts to mix with it a superabundance of chaff? Well, at any rate we ought to be watchful for any aggressive tendency to take what we want, or failing that to institute a talion revenge. I cannot help thinking that the method of dealing with refractory cases by setting a fixed termination has some resemblance to the oral urgencies of a highwayman's formula: ' Your associations or your analytical life '! But of course the highwayman, besides demanding magical sustenance from his environment, has an obvious and anal-sadistic drive to satisfy, and while we are dealing with this point of ' giving and getting ' in the interpretative and associating sense we may consider later modifications of the principle. Evidence of identification by the patient of the analytic situation with a urinary-erotic or anal-erotic situation is not hard to find: the ' flow ' of associations, the ' production ' of ' material ', or a condensation of both, as in the image used by one of my patients: ' a flow of golden sovereigns '. The latter visualized his associations as a urinary stream spraying out into drops which solidified and fell as pieces of money. In the same way with the analyst, positive urinary tendencies will tend to make him more communicative, negative anal tendencies more reserved. It is easy to see that when the pregenital primacies give way to genital primacy a link has been forged whereby the necessity to express oneself is related to genital achievement. This stage,

too, may be reflected in the analytic situation. But in fact the analytic situation is one in which for the analyst open self-expression of this sort is constantly thwarted, or is reduced to a more rarefied and highly adapted form, namely, technical interpretation. Interestingly enough, patients are prone to regard these interpretations unconsciously as a kind of sexual assault. Unconscious homosexual cases are very sensitive to what they feel are implantations of ideas in their minds, heterosexual situations are similarly represented, and cases whose unconscious conception of coitus is a sadistic one constantly solicit some ' active ' interference by the analyst. All this notwithstanding, practically all day and every day the analyst must listen : his desire for achievement must be indefinitely postponed.

To come back now to the attitude of the ego during the earlier stages. I think we may say that what characterizes it during this period is the fact that it is in the throes of fusing or defusing various instinctual tendencies. Let us take two examples. We are at the point where the instinct of aggression and mastery is ready to be diverted in part, so that it may ultimately serve genital function. It has already had erotic association at the earliest stage and is seen in this connection as oral sadism. It is now about to reach the flower of its development and expression in the anal-sadistic stage. At the same time certain connections have to be made between anal love-systems and genital love-systems which will permit carry-over. These are, briefly, fæces—penis—man—baby-getter, or fæces—baby—woman—baby-producer. At the same time the component sexual impulses are still preserving a sort of autonomy, but are beginning to allow their characteristic tendencies to be placed at the service of the expanding ego. So that, to state our two examples, we see in anal-sadistic and curiosity impulses a more or less close alliance between libido and ego tendencies. Now the motivation of psycho-analytic research derives possibly more impetus from the sublimation of these tendencies than from that of any other set of impulses ; it is mainly to analytic manifestations of this group on the analyst's part to which we must look if and when difficulties arise in the analysis, apart from those credited to the patient. We might almost say, ' When in difficulty think of your own repressed sadism '. As we have noted, the patient is quick to read into the analytic situation a sadistic significance, and I think we may assume that any unresolved sadistic impulses on the analyst's side would scent some possibility of gratification here. The close relation between sadism and viewing impulses, as well as

the relation between psycho-analysis and healing in general, tends to confirm this view. Nowhere is psychological viewing more complete than in the analytic situation.

Now apart from the fact that there is a great variety of positive indications of sadistic interests, it is obvious that the analyst's method of expressing these interests will depend on his immediate reaction to the patient. Should the patient be the *object*, or more strictly, should the patient be identified with objects of the analyst's own sadistic impulse, the manifestations will differ from those appearing when the analyst identifies himself with his patient and guards vicariously against sadistic aggression. In the first group we should observe a general tendency to ' put the patient through it ', or again a proneness to use analytical theory as a weapon with which to browbeat the patient into intellectual submission. The inclination to fall into theoretical argumentation belongs to the same group, or again a tendency to cap a consciously rejected interpretation with another of the same kind. If the interpretation is wide of the mark, it is better to leave it alone ; it will glide harmlessly off the patient's mind in any case. If it is right there is no need to repeat it : the patient's rejection is in this case merely the unconscious ' Yes '. On the whole a tendency to excessive interpretation is an indication for analytic scrutiny of one's own mental state.

On the other hand, should there be an undue inclination on the part of the analyst to guard against ideas of sadistic aggression, this will be evidenced by some over-solicitousness about the patient's reactions, a tendency to ' let him down lightly ', to come forward with unnecessary reassurances, to assist a patient out of a difficulty before the latter has realized that there *is* any difficulty. As the counterpart of excessive interpretation we may find an inclination to let moments for legitimate and necessary interpretation pass by. One particular analytic weapon may be adapted to the ends of either positive or reactive tendencies : it is the employment of silence. Seemingly a passive attitude, it may be used as a counter-attack, and it is easy to see that many patients read it in this way.

At this point it might well be advanced that there is nothing we can do or omit to do which could not be interpreted in terms of the analyst's own reaction. We seem to have landed ourselves in an *impasse*. I propose therefore to consider this problem of silence more fully. As has been suggested, it is necessary that a patient should realize that a difficulty *does* exist : on a varying number of occasions

it will be necessary for him to go through a prolonged silence unassisted. Indeed, the sooner one of these legitimate moments arrives the better. But at first, when judging from the patient's tempo we are certain that he has embarked on a silence, we are under obligation to encourage him to speak. This can be effected either with the help of the usual monosyllables, or by open encouragement to say what is in his mind, or by asking him whether there is anything in his mind causing him difficulty or distress, or by an explanation of the analytical significance of an analytic silence. Having given some such assurance or re-assurance, we need not repeat the process any more than we need repeat a valid interpretation. We must simply wait events. Assuming now that the difficulty has been overcome but that on a later occasion a silence occurs in connection with the *same* group of ideas, we are then entitled to meet it with interpretation instead of reassurance. But, provided we feel that our interpretation has covered the ground, a subsequent hitch related to the same set of ideas may be permitted to work itself through to unassisted speech. When, however, we have reason to think that *fresh* ground has been broken, we may legitimately adopt the same sequence of attitudes—encouragement, interpretation, silence. In this way the patient will experience all varieties of silence difficulties and the analyst will have avoided a semblance of stereotyped procedure which is sometimes highly inconvenient. To meet silence invariably with silence is to court a sort of silent combat, which confirms the obstinate or aggressive type of patient in his view that analysis is a kind of psychological pugilistic encounter to be settled by the gaining of points. On the other hand, this is precisely the type of patient to whom it is necessary to demonstrate that he is attempting to convert analysis into a fight, in fact that this is the outstanding evidence of his negative transference.

To come back to our discussion: *what distinguishes analytic technique proper from the gratification of unconscious attitudes is its adaptation to the unconscious requirements of the patient. Indications for self-inspection are: that we act always in a stereotyped way or that we cannot immediately justify our interventions or silences on good analytical grounds.* We cannot go far wrong if we always know not only why we intervene or are silent, but also what effect we hope to produce by so doing. *A third indication is that we cannot explain to ourselves satisfactorily why a patient is still in difficulty.* These considerations allow us ample latitude to alter our procedure in difficult or exceptional cases, the criterion being that we are fully aware of

the significance of our change in technique and the effects it may produce.

I am conscious that in these rather crudely expressed formulations I have neglected an important aspect of analytic technique. Just as the general clinician is able as the result of ripening experience to sense danger and to respond to indications for interference, as we say, almost instinctively, so the analyst will develop a sense of touch in his work which will enable him to time his interferences with some precision in varying circumstances. Moreover, the fact that his unconscious processes have been attuned to the processes going on in his patient's unconscious enables him to keep tally without conscious effort. But for the moment we are considering not only situations of difficulty in the patient's analysis but situations of difficulty in the analyst's mind. Hence I have permitted myself to exaggerate somewhat the rational estimation of reactions. Nevertheless I think it is true that even if the ideal analyst acts, as it were, on instinctive feeling, he would nevertheless have little difficulty in extending before us the processes giving rise to his action.

We have now a convenient opportunity of considering more closely what is actually meant by the terms counter-resistance and counter-transference. As a matter of fact, the term counter-transference covers most of the ground, in the sense that what we call counter-resistance is more often than not a manifestation of *negative* counter-transference. There are of course many instances of pure counter-resistance where opposition or attack on the analyst's ego acts as a stimulus and provokes the old-fashioned reactions of flight or counter-attack. It is perhaps not of any great practical moment whether we use these terms loosely or not, but to illustrate one of the commonest confusions we may return to our rough survey of the analyst's difficulties. If we assume that the anal-sadistic phase has been weathered, the stage of infantile genital or phallic primacy established, the ego advanced from a mainly narcissistic basis to a more organised relationship with complete objects, the difficulties likely to be observed are those connected with the positive and negative Œdipus relation and the resolution or completion of that situation under the spur of castration-anxiety. Now we are familiar with the fact that prolonged phases of difficulty in patients' analyses, which we call for convenience ' resistance ' periods, are on closer examination found to be more than simple mental defences. They are in fact repetitive situations, and are characterized by attitudes of hostility, depreciation and reserve.

So they are then called negative transferences. When we begin to resolve these negative transferences, it will be found that the resolution is accompanied by a release of anxiety and the outcropping of fresh castration imagery or the reactivation of already familiar castration phantasies. Hence we are entitled to conclude that the resistance phase was in effect a representation and repetition of the phase when the child apprehends punishment on account of positive Œdipus wishes. The resistance may not however be entirely resolved or, although seemingly resolved, it may recur after a short interval, and our next step is the recognition that as well as being related to the positive Œdipus situation, these resistance phases or negative transferences can serve as repetitions of the inverted Œdipus situation. The patient endeavours to realize his libidinal tendencies through the idiom of analytic hostility. We frequently note, for example, that great hostility to and depreciation of the personality of the analyst is accompanied by a seemingly illogical sensitiveness to any interpretation which is read in the sense of criticism, i.e. of attack. Moreover, appropriate interpretation will once more produce an efflorescence of castration images. This second factor in transference resistance is most easily observed by a male analyst during the analysis of a male patient or by a woman analyst during the analysis of a woman patient, but of course transference repetitions are not limited by the sex of the analyst, and the repetition of the *complete* Œdipus complex is an essential part of all analyses. Applying these findings to the position of the analyst, we can realize that sensitiveness to criticism may represent not only an ego-reaction to attack, but a specific sensitiveness to the libidinal significance of attack. In the latter event the analyst's defences are certain to be put to sore trial because in every satisfactory analysis there is no lack of transference depreciation. Reactions of this sort cannot be dismissed with the label of 'narcissism': the situation is in reality one of *negative counter-transference.* There are however many ingenious rationalizations of this state of affairs. The analyst may feel (sometimes avow) that his main analytical difficulty is really one of counter-transference in the *positive* sense, e.g. that he cannot help having positive interest in his patients' welfare and wants them to love him. The fact is, however, that he is uneasy during the patient's negative phases and that his longing for a positive atmosphere in the analysis is in greater or lesser part a sign of his need for reassurance. If he simply dreads castration in the sense of positive Œdipus guilt, the patient's friendliness will reassure him; if he unconsciously

hankers after the inverted Œdipus situation, the patient's hostility will rouse his defences.

Coming now to the more advanced stages of ego-differentiation, we have to consider what resemblances may exist between the analytic situation and the phase of Œdipus resolution which coincides with the formation and shaping of the super-ego organization. Starting out once more with the patient's point of view, we can see that for him the analytic situation is a dramatic representation of pre-ideal conditions, i.e. before the parents have been introjected. The parental imago is once more a real figure outside himself, and although the analyst does not behave like his predecessors, the revival of the situation under the process of free association makes it easy for the patient to re-animate his own old attitudes. He is by turn defiant and submissive, he loves and hates, he demands appreciation and apprehends hostility. The old compromises are turned to advantage ; burdened by guilt-feeling in himself he turns on the parent, attacking him by preference on matters concerning which he had as a child legitimate cause for grievance. Under external pressure the patient had to abjure stage by stage oral, anal and now genital satisfactions : yet his observations, amplified by a wealth of phantasy theorizing, told him that nowhere is his infantile situation reproduced more faithfully than by the parents themselves between themselves in the parental bedroom, bathroom and lavatory. So the parents' seemingly hypocritical satisfactions constitute a whipping-post on which the patient castigates his own deficiencies. In this sense he is the first of moral reformers. But in analysis we hear relatively little of these earlier observations and theorizings, criticisms and tirades. On the other hand we do observe, when transference repetition has reached this phase, an increasing tendency to become curious about the analyst's life and opinions. This represents an endeavour to find foothold for the transfer of phantasies, but it is not always an essential part of the procedure. Many patients do not tarry for alleged justifications but proceed to spin a web of phantasy concerning the analyst's private life, whilst others, seemingly more inhibited by lack of rational grounds, have only to be encouraged to phantasy, to produce very similar material. Other motivations apart (e.g. envy, hostility, etc.), these phantasies become more and more a recital of alleged shortcomings. In negativistic cases this may develop into a continuous tirade, during which the analyst is covered with reproaches and contumely, expressed in a tone of voice which leaves no doubt of the sadistic fury of the patient's super-ego. Now I

have already suggested that this is one of the most stimulating of situations for the analyst. His own super-ego formation, even if it has not been accompanied by such extreme defusion of sadistic impulses as that indicated here, has at any rate followed the same pattern of development, and if he has some unresolved difficulties in controlling his own super-ego it will be of little comfort to him to know that the patient is projecting self-criticisms. He is being attacked at the weakest spot in his armour, and if he winces or gives the slightest cry he may be certain that the patient will relentlessly press the attack home. Now of course there are various ways of wincing, but we are not concerned here with the more crude objurgatory methods of talion reaction, although these are anticipated by certain patients who remark after such critical passages, ' I wonder you don't put me out '. On the contrary, the most striking indications of reaction are, first, a tendency to begin interpretation of the projections with just a little shortening in the usual interval and a tendency to get side-tracked into considering the reality of the criticisms. A little haste or a little heat and the battle is lost. As an indication that some additional analytical toilet is necessary I would suggest a vague feeling that one is really ' quite calm '. On the other hand, complete indifference more often than not savours of a flight by regression to narcissistic omnipotence levels. The situation is a stimulating one, but it should produce neither aggressive reactions nor flight responses. The time taken by the patient to expand or exhaust his theme should be ample for any stabilizing which may be necessary on the analyst's part, and his ultimate reaction should be as detached as it is when in course of dream-reporting he recognizes himself in the inferior parts allotted to him by the patient during dream-work. To put the matter in terms of psychic systems, these criticisms should be sampled by the conscious ego and should arouse no more super-ego reaction than is included within the conscious levels of super-ego activity ; they should not awake in us a defence appropriate to the infantile ego—in other words, a criticism is not a castration. The next point is that whatever validity seems to lie in these criticisms has no more importance than the reality element of a rationalization. For example, the analyst may be characterized with every accent of sincerity as a low fellow, his mother probably a washerwoman, his wife socially impossible, his offspring mentally or physically defective, his intelligence inferior, his taste barbarous, his maids gawky, his newspapers philistine, his wall-paper a scream, his analysis incompetent, his aspect repulsive or

obscene, etc., etc. These are simple examples, but of course the more skilled the patient's tongue the more delicate will these and innumerable other innuendoes become. Now if somebody says ' You have a hole in your stocking ', we may, if we like, consider whether we have a hole or not, but that is not in itself important. We know that the criticism or observation was dictated first by hostility or envy, and secondly by projected guilt ; hence our analytic interest could be fully expressed in the form ' What does the *idea* of a hole in *my* stocking bring to *your* mind ? ' But I have suggested that in this projective work the patient discloses himself as the first of moral reformers, and I want to suggest now that should there be any unconscious necessity the analyst can in his work employ projection in the same expert manner, and can rationalize this tendency on the ground of therapeutic necessity. I think few analysts would admit to a conscious desire to ' reform ' their patients, but disguised representatives of this wish might conceivably get expression from time to time. In the field of clinical medicine reactions of this kind are scarcely disguised at all, e.g. an extension of the tendency to treat venereal disease or its sequelæ as taboo disorders is often reflected in vague aversions to the handling of skin diseases, malformations, etc. The parallel to this in the analytic situation would be where certain psycho-sexual manifestations, e.g. homosexual or other perversions, are regarded as curious artefacts, and a feeling of satisfaction is experienced when there is any indication that they are being modified or removed. It has often been said that the most satisfactory outcome of an analysis is where the patient departs relieved of his symptoms but without feeling in any way grateful, perhaps indeed tending to minimise the seriousness of his original complaint. It is too much to expect an analyst to be indifferent to the successful outcome of an analysis, but at least we may ensure that his satisfaction is not the result of a projected self-reforming impulse.

One need hardly add that there are pitfalls in the opposite direction. There is a point where the explanatory reassurances, which must occasionally be given in analysis in order to cope with manifestations of anxiety, may almost border on a refined process of rationalizing on the analyst's part, a tendency as it were to seek condonation of his own unconscious interests by a constant attitude of explanatory tolerance whenever his patient is in a specific difficulty. Needless to say, any inclination to over-explain must be suspect, or any tendency to selective explanation. There is, however, a more insidious way in which the analyst can express unconscious interest, viz. the avoidance

of interpretation, either on rationalized or purely unconscious grounds on occasions where some interference is indicated. Finally, a tendency to express agreement with opinions and attitudes expressed by the patient may conceal the desire to model the patient's ideal system on one's own image. After all, the essential remodelling is and must be done by the patient ; our task is to facilitate this process by providing the necessary conditions of security, detached interest and tolerance, and ultimately to remove obstacles to this remodelling by analytic interpretation. It is very often expedient to ' go ' with the patient, and it is sometimes prudent to concede freely what reality-elements exist in rationalizations. The concession, however, should always be qualified with a ' but——' calculated to head the patient in the direction of his own unconscious reactions.

The mechanisms we have dealt with so far have been selected from different stages of ego and libido development ; the list is not intended to be in any way exhaustive, and it may be freely conceded that the operation of some of these mechanisms would be sufficiently crude and obvious to prevent their going unnoticed for any length of time. Whilst this method of approaching the problem of counter-transference cannot be avoided, it is liable to give rise to some misapprehension. Without exaggerating the results of training analyses, it can be fairly said that massive reactions do not constitute the main difficulty. A surge of sadistic feeling is not difficult to recognize as such, whereas the repetition of a single phrase such as ' This is evidently a resistance ' or ' You are resisting ', or even of an interrogative ' Yes ? ' may conceal from oneself, though not always from one's patient, a deflated sadistic attitude. A resistance is after all best countered by an effective interpretation. In the same way it is by studying various minor indications of reaction on our own part that we can best recognize the preliminary signs of positive counter-transference. A slight inclination to agree with explanations offered by the patient, to become involved in any giving of advice, to be *satisfied* with any stage of the analysis prior to the last interview, to make a habit of exceeding by a few moments the customary time-limits of the session—these are but a few of the innumerable hints given us of the state of our own reactions.

It will be observed that little or no mention has been made of what might be called the silent manifestations underlying difficulties in handling the transference. Just as it is true to say of patients that their most effective resistances to analysis as a whole are more silent than the relatively noisy silences and pauses in association, so the

analyst's difficulties may be effectively concealed by the fact that he is a psycho-analyst. It is common experience that the most prolonged and stubborn of a patient's resistances are cloaked behind a ready intellectualistic acceptance of psycho-analytic theory, and I think it is generally conceded that at least some prospective analysts are attracted to the science by this intellectual shelter from inner difficulties. Theoretical acceptance in such cases will be found to break down when the ' transference neurosis ' threatens to develop: the candidate usually joins the ranks of those who break off in a partially analysed (more strictly unanalysed) state, to become in course of time frankly antagonistic, or to adopt the more ingenious defence of masquerading as *bonâ fide* ' open-minded ' analysts. Now whilst in these extreme cases this is an ill which cures itself, the *tendency* is one which has to be guarded against by all practising analysts. Analytic discoveries and convictions are a sort of *enclave* in the territory of science and in the mind of the individual, liable to be encroached upon from all sides. Of these attacks the most insidious are those from within the mind of the individual, and the only way of safeguarding what might conceivably be sapped is that constant attitude of individual watchfulness which we have described as the ' analyst's toilet '.

V

THE TRANSFERENCE-NEUROSIS

You will have observed that our discussion of counter-resistance and counter-transference has been inserted between the subject of resistance in general and consideration of the ' transference-neurosis '. In adopting this course I was influenced by two considerations. The first was simply that an overhaul of counter-resistance is a useful corrective to any review of the patient's resistances. The second will, I imagine, serve the purpose of introducing the present theme. *It is safe to say that at no stage of an analysis are the analyst's reactions, or his convictions about the fundamental truths of psycho-analysis, put to a more severe test than during that stage when the ground of the patient's conflict has been shifted, from external situations or internal maladaptations of a symptomatic sort, to the analytic situation itself.* So much so that I feel justified in commencing the discussion by repeating that the main objective of counter-resistance differs in no essential from the main objective of resistance, viz. flight from any real appreciation of the Œdipus situation. The analyst has indeed one defensive advantage over the patient in this respect : should his sensitiveness to the Œdipus situation still persist to any extent, he can disguise this fact from himself by the supreme rationalization of being a professional psycho-analyst, i.e. one whose main activities will be *in the direction of* resolving Œdipus conflict in others. I say ' in the direction of ' advisedly, because the intellectualistic view of analysis and interpretation is just as liable to prove a broken reed for the analyst as for the patient. It is not simply a desire to oust the parent that makes a patient attempt to conduct his own analysis or that stimulates him to ' take up analysis ' professionally ; he has in addition grasped the intellectualistic possibilities of defence which exist in analytic activity. In a word, for both analyst and patient the ' proof of the pudding ' is the transference.

In approaching the transference-neurosis we must recapture the sense of movement with which we were concerned in the opening phases. We saw then how, taking the average run of cases, the analysis

begins with a certain impetus which carries us up to a first critical period where there is some risk of the process being abandoned by the patient. We have been busy getting him ' going ' and keeping him going, sampling the type of defence shown and the main trends of unconscious preoccupation, easing obstacles, and at suitable moments preparing the ground for further work by interpretative explanations. To put the matter a little more technically, we may say that the difficulties we encounter in the opening phases are of threefold origin : (*a*) the nature of unconscious phantasy, together with (pre)conscious representations of these phantasies, (*b*) the nature of unconscious ego-reactions to phantasy-life together with (pre)conscious ego-reactions, and (*c*) the nature of spontaneous transference-reactions. In overcoming these difficulties we adopt two methods. The first is more or less direct, i.e. we draw attention to the existence of unconscious preoccupations and to the existence of unconscious ego-attitudes of defence. The second is indirect, in the sense that we illustrate the existence of unconscious preoccupations and reactions by reference to immediate transferences to ourselves. The amount of interference, though varying in individual cases, never exceeds the optimum amount required, viz. that which is necessary to aid the process of free association. Although our interpretations at this stage are rarely very deep (unless in exceptional cases), we have frequent opportunity of practising what might very loosely be termed libido analysis, ego analysis and transference analysis respectively. Hence without obscuring the picture, we accustom the patient to a new point of view (super-ego modification), and at the same time prepare the ground for future work.

Of course we have never really been blind to the fact that our work was only commencing. As we have seen, the patient's defences have been ready for every emergency, and we do well not to be hoodwinked by any progress he may seem to be making. Neither may we lay any unction to our technique if the symptoms seem to clear up ; indeed if they do clear up we must be ready to face a not long delayed attempt to shelve or closure the analysis. As I have said, when the first impetus dies down and our first set of difficulties have been overcome, we are soon made aware that the removal or alleviation of one set of defences is merely the signal for another set to commence operations. *In the average run of cases, this is evidenced by an at first almost imperceptible change in the atmosphere of the analysis.* Let us take, for example, what usually happens in a simple anxiety case. To begin with, we have as a rule been able to get a ' mixed bag ' of associations. Various emotional

experiences and crises have probably been *picked out*, but we are left with the impression, first that the affect was disproportionate in the sense of being exaggerated, and second, that it has not really been exhausted by the recital of these events. In the same way we learn at first a certain amount of historical detail about childhood, but that too is selectively presented. Nevertheless, watching the ' drift ' of unconscious associations, we have seen that it is concerned almost constantly with situations of an anxiety type, connected with ideas of loss, injury, depreciation, inferiority and so forth. To use one of the convenient labels, we get the impression that castration anxiety is a marked feature of the case. We shall probably have occasion to note that images of this sort have a fascination as well as a horror, that in various ways they seem to be courted, or that reported injury situations have been somehow engineered. We shall probably find similar evidence in the patient's dreams, which are vivid, accompanied by anxiety and concerned with variations on the general theme of loss. Some other characteristics are likely to be observed. A tendency to introjection, to include within the boundaries of the ego many external situations where emotional crises similar to those fostered by the patient may be found ; a tendency to soak up anxiety with the absorbent of external circumstances. Another tendency will become more and more obvious : *that the more recent the emotional situation experienced or observed the more amply it is elaborated.*

Now as to the type of defences, there can be little doubt that these are of the repression type of ego-resistance. The numerous pauses, halts and switches indicate the ego's intention to keep both id-excitations and super-ego criticism at a distance by withdrawal of cathexis. The patient does not ventilate all sorts of general reaction-formations ; indeed the main indication of reaction-formation is localized and selective ; it is represented by solicitude for the welfare of members of the family, a sort of localized ambivalence. When, however, we have spent some time examining these repression resistances, finding out what specific situation lies behind the pause, endeavouring to elicit still earlier examples and at the same time demonstrating the existence of anxiety-reactions which are not adequately explained by current or recent reality, the result of dealing with this first line of defences is interesting but not unexpected. *Instead of going backwards chronologically, we seem to come inevitably forward, i.e. to be more and more concerned with the present day.* Again, we find that instead of the minor pauses to which we have been accustomed, the whole analytic

session tends to be converted into one pause, in the sense that the patient brings forward each day a certain number of observations usually about matters concerned with the previous twenty-four hours and, having brought his diary up to date, intimates that there is nothing else in his mind. Moreover, he usually expresses the view that it is time the analyst did some talking and is inclined to resent any maintenance of passivity on his part.

In short, the whole analytic situation has taken on an entirely fresh complexion, and will maintain this complexion with various degrees of exaggeration throughout the second phase of analysis. *The transference-neurosis has commenced.* Two questions immediately arise here: first, why does one say that the transference-*neurosis* is just commencing, in view of the fact that transference-reactions have already been described as existing in the opening phase, and second, why not regard this concern with present-day matters as simply an exaggeration of existing defences? Now it is true that transference manifestations of some kind or another have been displayed from the beginning. To say that transference is everywhere is merely to say that displacement is a universal mechanism. In various ways—early dreams, slips of various sorts, certain associative material of a directly personal nature, and in general reactions to analysis—we are able to satisfy ourselves quite soon (indeed immediately) that the analyst has been fitted into various niches in the patient's mind, is being regarded with mixed feelings of affection and hostility. For example, the diffidence arising in the first few minutes of analysis is already conclusive proof of a displaced attitude. Moreover, we have already turned these reactions to advantage by interpreting them as transferences whenever a specific difficulty arose. Again, it is true that this preoccupation with current events implies a reinforcement of defence. But it would be just as simple for the patient to defend by means of a prolonged and minute recital of events concerned with adolescence or late childhood. Indeed, we know that in many obsessional types a great deal of historical elaboration, explanation and review, although ostensibly engaged in with a view to making everything ' quite clear ' to the analyst, is in part a defence of the usual reaction type. Without doubt these elaborate recitals are in the nature of explanatory apologies tendered to the patient's own super-ego, but they also serve the immediate purpose of deflecting attention, or, in other words, of making the emotional material opaque rather than clear, of obscuring the real issue with historical opacities.

Why, then, do hysterical cases choose current events for elaboration, and why is it that having made this selection they are unable to fill out the whole session with such preoccupations, but are soon brought to a halt for lack of anything further to say? *We are driven to the conclusion that the patient has been caught up in a forward sweep of libidinal interest, and that whilst it is certainly a defence in the respect that it is a sweep forward, away from memory work, it is one which is accompanied by peculiar difficulties, and is brought up short by quite specific hindrances. This sweep forward, this concern with current events, ends in a more or less complete 'jam' in the process of thinking, because its logical goal is preoccupation with the most immediate of all events, viz. life in the analytic room and immediate relations with the analyst.* Now this is a different state of affairs from that where the patient gives sporadic indications of unconscious transference, and the attitude of the patient is also different. For example, if in the earlier phases a patient desires to bring some little present or other to the analyst, or accidentally leaves a few coppers or a soiled handkerchief on the couch, or forgets all about an appointment, we are on safe ground if we interpret these actions to the patient as indications of a positive, ambivalent or negative attitude respectively. And the patient will very often accept these interpretations; not, of course, that this acceptance is either invariable or essential. But if we endeavour to suggest that this new preoccupation with current affairs is a more striking instance of the same group of reactions, and that it has an immediate personal significance we are faced with incredulity, repudiation or annoyance on his part. Moreover, he will begin to argue and will point out what is superficially true, that there is no evidence of such reactions in his associations.

At this point we may formulate our first generalizations about the transference-neurosis, viz. that *it differs from the more explosive indications of positive and negative transference as seen in early phases of analysis in that it is liable to pass unnoticed certainly by the patient, and in some cases by the analyst.* We may add as a rider to these propositions that *the main part of the analyst's work is to make this unconscious set of attitudes conscious.* I do not mean that the transference-neurosis never becomes exaggerated or explosive. It very obviously does so at times, and in fact the more we bring it into consciousness the better opportunity we have of measuring its strength. But I do mean that there is considerable risk of analytic failure if we go on the assumption that the transference-neurosis will in course

of time automatically manifest itself in a manner which will be convincing to the patient. The real essence of the transference-neurosis can be extracted only as the result of laborious attention on our part.

I have implied that conviction on the patient's part is essential to success, but as we have now familiarized ourselves with the processes of counter-resistance I need not apologize for the remark that conviction on the analyst's part is even more important. To come back to our example, the anxiety case has reached the stage where the flow of current associations soon dries up, and the view is expressed that it is time the analyst did some talking. Now if we are convinced of the psychic reality of transference phenomena, immediately the patient says 'Now its your turn to talk', we know two things: (*a*) that one of his unconscious phantasies is concerned with an infantile wish for some demonstration of love interest on the part of one or other parent. In the same way, when he reproaches us for not being active enough in analysis, we know that at least one of his set of infantile love-phantasies has had a considerable sadistic component. But this interpretation, whilst ultimately and fundamentally right, is at the moment wrong. At the moment it is the *analyst* who is asked to talk or to be more active. So our second piece of information is (*b*) that the patient's *unconscious phantasy* demands that the *analyst* should make love to him, and, in the case of the reproach about activity, that the analyst should make violent pregenital love to him. These, then, are for the moment the correct interpretations. Any amount of intellectualistic interpretation of the existence of infantile phantasies will be accepted by the patient, but the interpretation will butter no parsnips. The patient is only too glad to play Mother Hubbard to our analytical appetite so long as the real affective situation has been left untouched in the transference cupboard.

Now let us suppose that we have only one case on the treatment list and that an hysteric, suppose also that we do not feel quite sure of our ground in making transference interpretations, how are we to attain this clinical certainty as apart from personal convictions gained through training-analysis? My answer would be: take the first opportunity of analysing an obsessional neurotic. One of the characteristics of obsessional cases is that they have in consciousness ideas of which the hysteric is completely unaware. They seem in some respects to be completely unrepressed, although this is scarcely an accurate description, since if we examine the ideas in question they appear to have undergone a good deal of distortion and dis-

figurement. Another characteristic is that whilst pursuing one train of thought obsessional cases are at times vaguely aware of a parallel series, in which the same theme is being represented in a quite frankly erotic way. Some years ago an obsessional case was transferred to me after a partial analysis. (I emphasize the fact of transfer since it played a specific part in what I am about to describe.) On one occasion she began associating by saying, 'I want you to do the talking to-day'. A quick pause followed, during which she passed her hand over her face. A moment later she continued with some comment on what had been said in a previous session, and the usual fluent process of description, explanation, argument, doubt, elliptical reference, criss-crossing of ideas, etc., asserted itself. Now the phrase about my doing the talking was in itself seemingly superficial, but knowing that an obsessional never makes any gesture without some defensive purpose, I concluded that the gesture implied an attempt to shut out of her mind a parallel train of thought. So at the first moment I asked what had been in her mind at the beginning of the session. Her answer was 'An objectionable idea.' Gradually we were able to piece it together from associations, each one of which was accompanied by protests and repudiations, but none of which was stimulated or encouraged by me. I kept silence until the piecing process was complete. Like all obsessionals, she had a touching taboo intended to counteract masturbatory impulses, and this touching element had been carried over into her infantile phantasies as to the nature of adult coitus. It happened that her first analyst had given her some explanation of the significance of handling the genitals in coitus, particularly in reference to the question of activity and passivity (we need hardly be reminded that the obsessional disposition goes hand in hand with unconscious bisexual phantasies). So that when the phrase 'You do the talking' was uttered, she was aware of a fleeting thought, viz. 'You put it in.' The rest of the associations dealt with various reactions and ceremonials concerning eating and the desire for someone else to feed her, which had been in existence in one form or another since adolescence. The implications were perfectly clear in her own mind, but when at the end of the time I pointed out the existence of an unconscious erotic phantasy concerning myself, her attitude was that of a typical hysteric, viz. of violently affective repudiation. Next day I had the opportunity of conducting a slight experiment in passivity. The session commenced with a discussion of the qualities of two maidservants, one cheerful and impertinent but

sometimes helpful, the other phlegmatic, heavy, unenterprising, but quite respectful. While she spoke, my reading was as follows: 'The impertinent maid is the earlier analyst, the lumpish one myself. She resented the explanations given by the former: she read them as sexual advances and yet, whilst fearing them, she liked them. Hence she is reproaching me for my impotence or incapacity. The theme being about servants, there is probably some play on the word "service" as well as a veiled depreciating tendency.' At first I intended to break in with this interpretation as the transference phantasies were at the moment hindering progress, but partly through curiosity I delayed. At the end of the session she brought up as spontaneous associations every one of the interpretations I had had in mind, e.g. the significance of my not giving the same explanations of obscure genital practices between adults. I then said, 'So the lumpish maid was myself,' a remark which led on to a discussion of the veterinary significance of the word 'service'. I added, 'So in your phantasy I am represented as being sexually safer but more disappointing'. She hurried on to another theme, which filled out the remaining portion of the session. Next session she began by complaining that everything was pointless and useless, but as I had no further time for experimentation, I broke in to point out that this was the result of yesterday's work, that she was at the same time coming back to the unconscious phantasy, but disguising the return with the reassurance that analysis was no good, that I was impotent, that she was identifying me with a woman. This was promptly repudiated lock, stock and barrel, and the transference struggle was once more engaged.

Let us assume, however, that the foregoing example is unconvincing to you; that, in spite of the patient's unassisted expansion of the theme, you are inclined to give ear to her official emotional repudiation of the phantasy as recapitulated to her by the analyst. As we shall see later, this repudiation is extremely significant, but for the moment we will waive any further interpretation and seek for conviction amongst the narcissistic neuroses. Patients suffering from these latter disorders very often have the most acute insight into the significance of their everyday actions and ideas and will accept as obvious interpretations which would appear outrageously far-fetched to the hysteric or obsessional. When they desire to repudiate an interpretation, they effect their purpose on many occasions by a conscious attitude of immunity and indifference. 'You think so', they will sometimes say, 'and you may be right . . . but it doesn't

appear so to me : I feel nothing of it '. However, let us observe the first few minutes of a session during the analysis of a case of depression. The patient enters the room, lies down on the couch, puts her hands to the ends of a hard oblong buckle, turns it up, looks at the reverse side, turns it back, drops it and puts her hands to her side. We happen to be in a period of remission and her object-relations are more apparent, although clearly anal-sadistic in type. So in the momentary pause which follows these actions, my reading is broadly that she is acting out on a miniature stage an unconscious erotic phantasy, in which she starts with an active exhibitionistic scene of lifting up her clothes, exposing the genitals to a lover (father) who greatly admires them. I realize, too, the hostile element of the phantasy, the defiant display, the anal regressional element (the back of the buckle), the coitus phantasy, also partly homosexual (the male and female parts of the buckle rather similar in shape), and there occurs to my mind innumerable fragments of phantasies on these lines which have been indicated from time to time during previous work. I wait a few moments with the intention of calling her attention to the gestures, should she make no spontaneous reference to them. But on this occasion there is no necessity to say ' What about the buckle ? ' She goes on immediately to say ' Did you see me touch my buckle ? ' and then without pause spins an erotic phantasy which is almost idea by idea what had suggested itself to me.

During this digression we have left our hysteric on the couch repeating that it is time the analyst talked, and we may return for a moment to observe that we now know what is meant by this request. We may also remark that by then it really is time to do some talking, but talking of the kind which is not emotionally relished by the patient. I mean, of course, transference-interpretation. We may here proceed to another generalization about the transference-neurosis, viz., that *from the time we have ascertained that this transference situation is developing, everything that takes place during the analytic session, every thought, action, gesture, every reference to external thought and action, every inhibition of thought or action, relates to the transference-situation. Moreover, if we feel it necessary to do so, we may break in with a transference-interpretation at any time in the session.* We shall always be correct if we interpret any thought or action in accordance with unconscious phantasies relating to ourselves. *But*, we must add, *it is necessary to have some rhyme and reason for such interpretation.* We might say that we have set a kettle on the hob in the hope of ' bringing

it to the boil', and that whilst a lot of our preliminary work is concerned with the fire and dampers, we must keep an eye on the kettle and be ready to interpret whatever splutterings go on during our other work. But whilst we can if we wish always lift the lid, it is advisable to do so only when there is some point in this procedure. When, for example, should we draw the hysteric's attention to the significance of these transference manifestations?

Before answering this question, I wish to return to the obsessional case I mentioned, to see if we can gather any further information of practical use. Now as a matter of general interest we may remember how this patient regarded explanations given by the analyst as the equivalent unconsciously of an erotic advance. This is in keeping with what we have mentioned often before; that the whole process of analysis is regarded in general as an infantile erotic situation and often specifically as a kind of sexual attack. We can appreciate then the validity of regarding the patient's own associations as representing for his unconscious an equally infantile form of activity. The analyst's passive attitude is then a sign of femininity, and the patient's desire to regulate the analysis with explanatory passages and home-made interpretations, represents a masculine attitude. But, as has already been suggested, one of the most important events in the sequence was the fact that the patient violently repudiated what was really less an interpretation than a simple recapitulation of her own ideas and statements. Here at any rate was some of the long-lost obsessional affect; it could be released freely only when some *other* person was guilty of the crime of openly expanding an erotic phantasy. But it was more than an expression of affect; it brought clearly into consciousness the existence of a repudiating attitude, a censoring activity of the ego, which could be indulged at someone else's expense. So that *the reaction to the transference-interpretation was actually a continuance of transference-activity* aided by the process of projection. Our transference-interpretation was therefore incomplete; the unconscious phantasy had been ventilated to some extent, but the unconscious ego-reaction had still to be brought home by a reversal of her projective defence.

An illustration of this kind suffers from the absence of context. All we have done so far is to indicate that if we have the courage of our convictions as to the reality of transference-relations we can make a sufficiently accurate interpretation at any time after the transference-neurosis has commenced. We have considered one or two simple examples of erotic transference-phantasy which were very near to

consciousness, and must leave it to be assumed that much more complicated ideas and situations are repeated in the transference in a similar way. Now you might ask: what was the general significance of the manifestations of the obsessional case at that particular time, how did they relate to the course of the analysis? Suppose one does uncover a transference-phantasy, what advantage is to be gained by so doing, what shall we say if the patient turns on us with the question 'What about it?'

Now whilst I cannot for reasons of space enter into the whole history of a neurosis, I can point out that for some time before these incidents occurred I had observed the usual signs of a forward movement in this patient's phantasy life. The obsessional's current affect is in a descriptive sense not comparable with that of the hysteric; there are not the same declamatory passages and not the same glaring amnesias. Nevertheless one can gauge their feelings just as simply by noting their reaction-formations, negations, ellipses and elaborations. Direct expression of affect can, moreover, be observed in certain displaced directions. Where an hysteric will spend endless time consciously rejecting, say, an obscene word, the obsessional will spend the same time in an agony of confusion over a simple nursery phrase, e.g. 'Diddums' or 'Ducky'. Whilst an hysteric is rendered speechless by a hectic erotic phantasy, an obsessional wails loudly over a seemingly innocent piece of sentimentality, the super-ego having scented out the more primitive construction underlying the latter. Going on these indications, together with some dream observations, I concluded that the slowing down of analysis was due to transference-phantasies. This was my main reason for interference. After a good deal of repudiation we succeeded in partial elaboration of phantasies concerning myself, and some additional fragments of information concerning her early life were obtained; these were interpolated almost casually during the phantasy expansion. But in fact the transference-phantasies afforded information of quite another kind. They clinched some opinions I had formed as to the *importance of certain identifications* in the patient's development. I need not go into the significance of anal fixations on a bisexual disposition, but, as you can see, the 'talking' phantasy and the 'servant' phantasy were essentially related to a conflict or fusion of heterosexual and homosexual impulses. Now her attitude throughout analysis had alternated between amenability coupled with a desire for more active treatment and depreciation of me coupled with a tendency to do her own analysis. Here then

was an opportunity of making reference to these alternating attitudes and of linking them on the one hand to the phantasy-content and on the other to unconscious ego-attitudes. The sequence of transference-interpretation in this case was then : uncovering the phantasy, noting the affect, reversing the subsequent projection of self-criticism, relating previous analytical attitudes to the phantasy-core, and endeavouring to recognize the specific super-ego component responsible for the censoring activity. The order of these events is of course arbitrary ; under other circumstances transference-interpretation might have commenced at some other point, e.g. projected self-criticism. One need hardly add that transference-interpretations are in practice seldom so extensive as suggested above. On many occasions it is enough at the time to call attention to the actual re-staging of phantasy in analysis, without any endeavour to link this up in the general way I have suggested. At the same time it is well to remember that a transference-interpretation of phantasy is incomplete, and that as a general rule our next transference-interpretation will be concerned with transference-indications of defence.

We may now attempt to tabulate the kind of information we expect to get from the transference-neurosis and generally the use we seek to make of that information. First of all we amass numerous *fragments* of information about infantile development and modes of thought, and we note numerous *minor* reactions which may not have been directly or only in part ventilated in association. Typical examples are the reactions to minor details in the analytic situation, noises heard, particular objects in the room, isolated reactions alleged to have been exhibited by the analyst. A slight rattling noise made by me annoys a patient, but reminds him that his father, who died when he was young, used to rattle pills, and in his terminal illness suffered from fæcal incontinence. Next come various transference-phenomena of short duration which are evidence of different identifications and relations to parental images in the patient's mind. Generally speaking, then, we collect pieces of information which may fit into a vague outline of the patient's development forming in our mind, and we classify these pieces of information into (1) facts bearing on libido-development, and (2) facts bearing on ego-development. This division is more definite when we consider *protracted movements* in the transference neurosis. A patient will, for example, work hard to establish a certain situation in analysis ; it may be in some cases essentially a passive homosexual situation or again a situation modelled on the positive

Œdipus relationship. The analytical equivalents of these situations are very numerous ; these patients may act constantly as if they were the sole object of analytic attention, will use their resistances with an eye to provoking counter-resistance, will constantly complain that their analysis is pointless and that the analyst is omitting something important. On the other hand, as soon as any effective interpretation is done, they will round on the analyst with anger and suspicion, fly up in arms to rebut what they take to be a form of criticism and in fact behave as if they were threatened with castration. First, then, we recognize specific situations which are re-enacted over and over again over a prolonged period ; these include all sorts of repetitions modelled on the cardinal variations of the Œdipus relationship changing from complete positive to complete negative, from direct to inverted. Moreover, we find that these are presented in different guises, that there is as it were a polyglot edition of the transference. For example, we have described above a re-enacted genital relationship. But in a constantly recurring set of reactions concerning analytic time, money, waste, etc., we can recognize an edition of the same play rendered in the anal-erotic dialect. Secondly, there are many protracted situations in analysis which provide us with evidence of important identifications. These should throw some light on *ego*-formations, especially on the nature and development of the *ego-ideal.* You will remember that from the ego point of view, the second stage of analysis consisted in exploring the early development of the ego and in estimating which identifications and introjections had played a decisive part in the formation of the ideal. In the transference-neurosis we see the introjections once more projected, and we are able to estimate from the strength and quality of the projected situations the nature of super-ego development.

Now in the case of transference-manifestations which we examine from the *libidinal* point of view in order to learn and reconstruct infantile development, it is not essential to follow too closely the order in which they appear. They can usually be fitted into a general scheme of development, and the main difficulty is to be certain of the *date* of the manifestations, e.g. whether oral phantasies played out in analysis are primary or the result of displacement. In the case of manifestations from which we infer the course of *ego*-development, it is more important to note the order in which different phases of identification occur. As a rule we find that in course of ego-analysis there is a general drift *backwards* which reaches its climax when analysis is nearing its

termination. This view of the process helps us to understand the true defensive significance of the *forward* drift of interest and preoccupation represented by the transference-neurosis. If there were no transference-defences we should probably be able to have an uninterrupted view of the various stages of ego-development, and should observe how as soon as one identification was analysed an earlier one would take its place. The transference movements tend to blur this impression, and if left unanalysed the ultimate effect is as ragged as the rendering of a symphony by a one-man orchestra. But this confusion is not the only difficulty ; on many occasions one set of identifications may be highly charged for defensive purposes. For example, when a patient shows signs of extreme castration-anxiety, the early indications may point quite simply to the fact that the analyst is being identified with the father-images. Shortly afterwards we may have occasion to note that the identification system has changed materially, and that the analyst is being reacted to on the strength of a mother-identification. Now, whilst this is in keeping with the general line of development, it has also a defensive significance. It is true that the mother images are invested with dangerous possibilities, but the curious thing is that during this phase father anxiety largely disappears. Under these circumstances we may be certain that we shall have to return later to work through a considerable reserve of castration anxiety relating to the father.

Before leaving this subject of ego-identifications and their analysis which admittedly represents the most difficult side of analytic work, we may console ourselves with certain legitimate reassurances. In the first place, although our early impressions of the patient's ego, as seen in the transference, are kaleidoscopic, the main phases of identification are not very numerous, and it is possible with experience to sort them out quite quickly, just as it is possible to classify with some ease the multitudinous representatives of an oral, anal or genital phantasy. Again, although the transference certainly blurs our impressions, it is not without its advantages. A projection may be very sharply defined, and its reversal provides us with a very accurate *ad hoc* interpretation. Besides, we are not simply marooned with transference-projections ; the patient will continue to provide us with information from other sources. In general, phantasy elaborations are followed by specific ego-reactions, and sometimes changes in the tone of voice or the use of certain stereotyped critical phrases is a certain hall-mark of the origin of these reactions. Indeed, if we ask the patient to repeat their

last remark in the same tone of voice, they will often spontaneously observe : ' Oh, my mother spoke that way . . . ' or ' . . . used that phrase '. Lastly, we may recall that in most cases we have not been pitchforked into transference-analysis : although in the earlier phase we interpreted to remove obstacles to association, we continued to gather from slips, parapraxes, etc., increasing information about the main lines of ego-development. From the first our general policy has been the same : to remove obstacles and at the same time to extract information from each difficulty. The transference from first to last operates as a defence, but as time goes on we make more and more use of the information gained. We use this first of all in the hope of increasing the patient's memory-work, or, failing any result, we employ it to reconstruct before the patient forgotten or irrecoverable parts of his development. Transference interpretation has to be used as a lever, and the time to use it is when the analytic superficies shows signs of petrification.

Armed with this policy, we can now return at long last to the hysteric on the couch who is demanding that we should ' do the talking '. From our observations of a ' forward drift ', from the drying up of tributary sources of information, we know that it is time then to do some talking, i.e. to give some transference-interpretation. But the first observation we make is that our policy does not seem to work. We suggest at first that this demand for us to do the talking is the conscious representative of an unconscious phantasy concerning ourselves ; the patient denies it. Fortified by an additional set of associations which indicates unmistakably the main outline of the phantasy, we go on to sketch out this phantasy as it is represented unconsciously in relation to ourselves, e.g. that it is an infantile sexual phantasy. The repudiation is still more emphatic. In most cases we are content for the moment with this repudiation ; it is the unconscious ' Yes '. But we must then observe carefully what happens when the repudiating attitude has died down ; we have to note whether any progress is made, whether the associations show any sign of backward drift as opposed to present-day preoccupation ; whether the same or similar phantasies appear in dream-life with any additional material, or whether the defensive mechanisms seem more marked. If, as frequently happens, no such signs of progress appear, we may safely conclude that the transference-phantasies are still too highly charged, and should take the first opportunity of ventilating them further. But what constitutes an early opportunity ? At first sight the answer

would appear to be simple, viz. when any positive indications, such as slips, or negative indications such as pauses, indicate that the patient is involved in transference-preoccupations. In many cases these occur so frequently that there is no difficulty in finding an opening. But the point I want to make is that *we are under no necessity to wait for such obvious openings*. As I have said, we can always lift the lid of the transference boiler, and the first opportunity is really determined by the conviction which grows on us that the analysis is still being held up. Just as in general we interpret when we feel convinced from the patient's associations that the time is ripe, so in this special case of transference-interpretation we make this when we feel convinced from the patient's associations that some further ventilation is necessary. The time being ripe, the opportunity is immediately present. *The transference-situation is always there.* Further interference is guided by the rules we have given in considering resistance. First of all, are we satisfied that our original interpretation is valid ? If so, we allow time for working through. If not—and it is better in the first instance to go on this assumption—the problem arises : what have we been missing ? Having satisfied ourselves on this point, we expand the transference-interpretation in this direction, checking our results always with the amount of additional historical information gleaned, or the amount of emotional reaction we produce, or the occurrence of transitory symptoms.

At this point I think it will be clear why it is important to divide translation of transference-manifestations into libido-explanations and ego-explanations. It is no use simply making libido-explanations if we neglect the fact that these infantile remainders are repudiated not so much by the conscious ego as by the *unconscious infantile ego*, and that the transference-*resistances* are themselves evidence of the operation of the infantile ego. In short the transference-resistances are an integral part of the transference and have to be translated as such. This explains why, when we first tackle an hysteric with transference-interpretation, our formulated policy does not seem to work. We have not completed our interpretations.

We see then that there is no essential difference between the *aim* of interpretation as a whole and the *aim* of transference-interpretation. All interpretations can be classified in accordance with their aim into (1) interpretations calculated to overcome immediate obstacles, and (2) interpretations leading back to the unconscious roots of the transference-phantasy from both the ego and libido point of view. I think

it is important to have some such rough distinction, and for the following reason: In describing analytic situations, phrases are often used such as 'This evidently meant the mother' or 'That evidently meant the father', and, although these are doubtless perfectly correct conclusions, one gets the impression that they are somehow isolated from the context, that interpretations couched in this particular form would mean little or nothing to the patient. Now assuming that someone begins to show in analysis an unmistakable sign of hostility to the mother-image, the immediate use we make of this observation depends on the state of the analysis. If the analysis is for the time being held up, the transference-interpretation can be given for its immediate effect. But suppose the analysis continues, and the reaction persists, it is necessary to extract something further from the situation. We may then cast about in our own minds in order to orientate ourselves concerning this reaction. After all we have a good deal of preconscious material to refer to, presumably a quantity of dream-material, we have various screen-memories noted earlier in the analysis, we have evidence of fixations in or regressions to certain stages of infantile development, we have the symptom picture, transitory formations, movements of libido outside analysis; in fact we have a mine of information which should help us to 'place' this mother hostility. So that having demonstrated to the patient the existence of this hostility reaction, our next task is the demonstration of the persistence of an older reaction. In other words, *we are never finished with a transference-interpretation until it is finally brought home to roost. To establish the existence of a transference-phantasy is only half of our work; it must be detached once more and brought into direct association with infantile life.* But although there is no essential difference in *aim* between transference-interpretation and other types of interpretation, there is some difference in the *effect* produced. In the usual interpretation we supply certain important word-bridges which enable communications to be established more effectively between the unconscious and preconscious systems. A happily placed bridge may sometimes give rise to quite an explosive discharge of affect and (or) some revival of memory, but in many instances work of this kind has no immediate result. Now in transference-interpretation, owing to the element of dramatisation, an effective interpretation is more convincing, in that the patient has come as near as possible to actual experience. But it is most convincing of all where we are able to demonstrate the discrepancy between the affect and the actual triviality

of its occasion. We have never at any time played any of the parts allotted to us by the patient, so that when a phantasy comes to a head we are able to reap some reward from this careful attitude of detachment. This we shall find later is a key position in all discussion of ' active therapy '.

But, as I have indicated, we must not pin our hopes on the invariable success of transference-interpretations. At the beginning of this lecture I said that at no stage were the analyst's convictions put to a more severe test than during the transference-neurosis. I must now substantiate this statement. The best method of doing so is to indicate generally the types of reaction in different neurotic states. In the case of the hysteric transference-reactions will become extremely heated, but owing to the strength of their preoccupations with the immediate environment it is difficult for these patients to recognize the obviously exaggerated nature of their attitudes. When, however, we do succeed in driving a transference-interpretation home, we are rewarded as a rule with some fresh piece of memory-work. The defensive process is, however, immediately renewed, and so we go on throughout a turbulent situation uncovering phantasies, stimulating memory-work, but giving respite every now and then to allow for absorption. In fact, the situation is so dramatic that we are never long in any doubt about the reality of the transference. The main possibilities of error are (1) that we may not recognize the change in analysis early enough ; (2) that we do not appreciate how far the hectic transference is covering hostility phantasies ; (3) that owing to the obvious nature of the phantasies we hurry things too much.

In obsessional types, the problem is somewhat different. We are apt to be misled by the existence of numerous word-bridges ; many ideas normally repressed are with them present in consciousness. As a matter of fact these bridges are in a state of defensive disrepair and have to be put in order, but in any case you can see that we cannot expect the same number of dramatic recoveries in memory-work as we get with the hysteric. Hence it is more essential that the transference-interpretation should be extremely convincing, and should give rise to a relatively greater amount of affective discharge. Moreover, the hostility factor is more important and gives rise to especial difficulty. Owing to the nature of the obsessional disposition and libidinal regression, the aggressive components are of a more primitive order. On the other hand, the super-ego sensitiveness and severity is correspondingly increased, so that negative manifestations as a whole,

and particularly those negative manifestations which have fundamentally an erotic significance, are opposed by reaction-formations. The obsessional plays constantly on muted strings, and the *motif* is spun out in interminable variations. So that apart from the usual tendency to miss early signs of the transference, there is a constant danger of loosening our grip of whatever transference-situation we have uncovered. To a certain extent we are protected against this by the failure in repression of presentations, but this is more than counterbalanced by the patient's ingenious mechanisms for dealing with affect. *I think this explains why after a seemingly model analysis we may suddenly feel that the ground has slipped from under our feet, that we don't quite know where we are or what stage we are in. When this happens we may be certain that we are in the second stage, viz. the transference-neurosis, but that for the moment our conviction about the psychic reality of transference-manifestations has faltered, that we have been tempted by the attractions of direct interpretation to neglect transference-interpretation.*

When we turn from obsessional neurosis to narcissistic neuroses we have to keep in mind two main factors: (1) that whilst at times the manifestations of positive transference may appear almost hectic, they have a more urgent defensive function. It is more difficult then to bring about in the patient that state of conviction about the nature of transference-phantasy, and it must be absorbed in infinitely smaller doses. Erotomaniac phantasies are of this defensive order and belong, I imagine, to transference paranoias. On the other hand, the aggressive components are more accentuated in these cases and may be evidenced by a long-drawn-out situation of concealed negative transference, varied by occasional explosive outbursts.

But perhaps the best example of all is the alleged normal person who comes to analysis for some emotional maladaptation, and is found to have a personality riddled with minor abnormalities, any of which, if exaggerated, would give a classical neurotic outline to the case. Here we are hampered by all the factors which may appear individually in the analysis of outspoken neurosis. We have some of that deceptive insight and interest into analytic points of view, minor anxiety-formations, obsessional symptoms or perversions, varying tendencies to introjection and projection, occasional explosive affect but more often persistent negative transference, silent and unrelenting, and finally no very urgent drive with which to counteract the discomfort of analytic integration. *Here there is some risk of missing the transference-situation altogether,* and here more than any-

where else is the point of view valid that the transference-neurosis must be *uncovered*, that it does not dance attendance on the analytic rule. It is always present but does not beckon to us, and the patient, having established a successful defence of neutrality and so cloaked the degree of his ambivalence, will certainly not abandon this defence by allowing any emotional reactions to come into the analytic situation. It is with cases of this type that we feel most inclined to doubt the validity of dividing analysis into stages and feel sceptical about the existence of transference-neurosis or of terminal stages. But the fact is that we are then in the thick of an undigested second stage. Perhaps I might suggest here the order in which we may profitably study or select case-material. We do well to study first of all the hysteric, to follow on with the obsessional, but as a prelude to further effort with narcissistic neuroses to sandwich in at this point an alleged normal.

Consideration of the transference-reactions of alleged normal individuals encourages me to make a final reference to the question of *policy* in transference-interpretation. Some analysts have a rough rule that, in the case of dream-symbolism and transference-interpretation, they delay making a direct interpretation until the patient has arrived spontaneously at the meaning of some one symbol or some one transference-reaction. Thereafter they are prepared to make direct interpretations of symbols and transferences at any time they consider appropriate, a method which, of course, appeals to the intellectual side of the patient's attitude. But apart from the fact that we do not embark on analysis in order to proselytise, and that we tend to pay for intellectual conviction by emotional refractoriness, the experience gained from 'normal' types shows us that some patients will never see any unconscious derivations unassisted, whilst others, who do recognize them at once, are in no better case until their affective inhibitions have been removed. Hence there can be no harm in repeating that what determines the moment for transference-interpretation is the slowing of movement or decrease of fluidity in the analytic situation.

Obviously it is impossible to do the subject of transference-neurosis justice in one lecture. I will, therefore, conclude by recapitulating the main points I have endeavoured to illustrate on this occasion, viz. :—

1. That owing to the superficial resemblance between general indications of transference as seen in the earlier stages of analysis

and the transference-neurosis proper, the latter is apt to be overlooked when it first begins to expand.

2. That from the time the transference-neurosis commences all analytic manifestations relate to it.

3. That if we do not see it openly manifested on the analytic superficies we must take steps to uncover it. In so doing we are guided by the general rules of interpretation as follows :—

(*a*) That we interpret to remove obstacles to progress.

(*b*) That we interpret to reconstruct the infantile development of the individual culminating in the Œdipus situation.

(*c*) That this involves analysis of the infantile ego as well as recapitulation of infantile libidinal relations (transference-resistances represent the infantile ego in full function).

(*d*) That with a finger on the pulse of resistance we space our interpretations to allow for absorption and 'working through'.

4. That the transference-neurosis has a more or less characteristic course in different disorders, but follows the same outline in all.

5. That in so-called 'normal' types and 'characterological' cases the transference tends to slip through our fingers.

6. That whenever this occurs our own convictions tend to be shaken.

7. But that we can always re-establish contact by immediate transference-interpretation of current material.

VI

TERMINAL PHASES

The problem of terminating an analysis illustrates very clearly the fundamental difference between psycho-analysis and all other methods of treatment. It has often been said that even if a physician could avoid the transference-factor in treatment his patients would nevertheless insist on treating themselves by means of transferences. As a matter of fact, every physician, whether he knows it or not, exploits transference methods, and never more wholeheartedly than when he is in a difficulty. But however skilfully he may utilize his patient's emotional reactions, he is under no obligation to dissolve these transferences. The psycho-analyst's lot is a harder one : he must utilize, uncover and finally dissolve the patient's transference. His cures are therefore the more striking that he has no other ultimate premium to

indicate than can be wrested by the patient through more effective adaptation.

Whilst the general practitioner has much to learn from the psycho-analyst concerning the handling of his cases, there is one particular in which the psycho-analyst would do well to study the practitioner's point of view, viz. his attitude to intractable but not necessarily incurable cases. Although transference-factors play an important part in the treatment of acute and sub-acute organic disease, their existence is seldom recognized: it is mainly in the treatment of chronic ailments that the patient's ' gain ' mechanisms and negative transferences, or the physician's counter-resistances, are likely to play an obvious part. But even when emotional reactions begin to operate quite obviously, it seldom occurs to the physician to consider whether or not his patient should be cured within a certain time or to search his conscience if there is any delay in recovery. He calmly lays the onus on the patient and proceeds unruffled with the daily visit. When negative therapeutic reactions can no longer be denied and some change in policy becomes imperative, the physician does not abandon transference technique; he sends a refractory case for a ' change ', which is after all merely experimenting with an altered set of transferences. In short, the stability and success of a physician's private practice depends very largely on the maintenance of durable transference-relations between himself and his clientele of ' chronics '. So when elderly ladies seek refuge from life in alimentary troubles or develop any of the numerous disorders which go by the name of auto-intoxication sequelæ, or lift the lid of the Pandora box of pelvic disorder; when elderly men extract secondary gain from intractable conditions of the various mucous membranes, from the naso-pharynx to the urethra; when the fibroid type of tubercle becomes a relatively healthy invalid; in fact, when the bulk of a general practitioner's chronic list have ensconced themselves in an atmosphere of valetudinarian privilege and dug themselves securely into domestic or social safety, the family doctor is not a whit disturbed but continues to dose out the transference in 6-oz. bottles, or vaccine ampoules or pluriglandular extracts. In other words, *he never dissolves the transference.*

As we have said before, the psycho-analyst in relation to his treatment tends to suffer from a sharpened conscience. He is not satisfied with that alleviation of symptoms which often fundamentally represents a stale-mate in true recovery of powers of adaptation; he

tends to become uneasy over what he considers undue prolongation of the processes of cure and to blame his technique when a patient refuses to abandon the gain through illness or, as Freud has put it, to melt down his neurotic defences in the heat of the transference. The possibility of technical miscarriages cannot be neglected, and we shall have occasion to refer to these later. In the meanwhile we may consider two groups of factors which help to bring about this attitude on the part of the analyst. The first group is mainly external in origin, and is chiefly concerned with the selection of cases. To begin with, it is well known that the analyst has to cut his teeth on the most difficult and intractable cases in the medical calendar. Unfortunate patients who have revolted against the psychological inadequacies of the general clinical outlook usually run the gauntlet of all sorts of treatment by camouflaged transference-methods before they arrive, sceptical and dejected, on the analyst's doorstep. Indeed, it is no exaggeration to say that, up to the present, legitimate analytic case-material is largely ambushed by the wayside. Moreover, the application of analytic methods now covers a much wider field than formerly, including, as well as the transference-neuroses, many narcissistic neuroses, all sorts of emotional maladaptations, character peculiarities, and so forth. This brings us immediately to the second group of factors, which are mainly internal in origin. Accustomed to watch the development of psycho-analytic theory and technique as applicable to the transference-neuroses proper, the analyst has tended to look for the same phenomena in the analysis of his other cases. It is the old problem of rigidity in outlook, of assuming that because the method of analysis is the same in all cases, the course of treatment, or in other words the patient's reaction, will follow the classical outline. Whoever handles a psycho-analytical practice in this anticipation is doomed to a good deal of disappointment and self-questioning. Apart from this, we may recall two of the mechanisms suggested in a previous lecture : first, the tendency of the analyst to identify himself with his patient and with his patient's pocket, and second, the unconscious reaction of impatience to any thwarting of his therapeutic intention.

I have advanced these preliminary considerations in some detail because in my experience the problem of how and when to terminate an analysis is one which exercises the imagination of many analytical practitioners. It is, moreover, a problem which has become more acute since the introduction of some devices of ' active therapy ', intended to shorten the course of treatment in certain instances. The

existence of active therapeutic technique is in itself an indication of anxiety on the analyst's part concerning the protracted nature of analytic treatment, and we must leave until later any consideration of whether this anxiety is of an entirely 'real' nature or whether it is stimulated in part by unconscious reactions. In the meantime we may reassure ourselves somewhat by the reminder that prolonged treatment with incalculable social and economic consequences is a state of affairs which the general practitioner treats with the calm born of great familiarity.

Turning now from the question of attitude on the part of the analyst to consider the actual clinical material, the first observation we have to make helps us to realize why the terminal stage of analysis is a matter for so much preoccupation. The fact is that owing to various circumstances, both internal and external, e.g. internal resistances, economic factors, the nature of the patient's emotional milieu, intercurrent or permanent organic illness and so forth, the opportunities of watching a classical analysis to its legitimate termination are, at any rate at the beginning of analytic practice, less frequent than is generally supposed. *What is often regarded by the analyst as a perplexing terminal stage is often nothing more or less than a normal case in a stage of protracted working through, that is to say, a case in which the terminal phase has not yet been reached but where the analyst will shortly be faced with the decision as to the advisability of initiating the terminal phase.*

I should not like to give the impression, however, that in all cases where for some reason or other a full analysis is not possible, the ending of analysis is of an abrupt nature, that it simply stops short without presenting any of the characteristics of a normal terminal phase. On the contrary, in all cases except those where by force of external circumstances the analysis is discontinued without notice, we discover the same resistances, the same regressional movements and the same attempt to take flight from reality, to retreat from newly won positions, which we shall shortly have to describe. Indeed, it would appear that there are exceptions to the rule I have already hinted at, viz. that the termination of analysis, like its initiation, is a step which must be taken by the analyst himself to the best of his judgement. One meets with cases where, in spite of a somewhat limited term being available, the pressure of circumstances appealing mostly to the necessities of the ego permit the completion of an analysis which, from the point of view of symptom-alleviation, may

be regarded as effective. And here, although no intervention is made by the physician, the last few months are found to exhibit the customary terminal characteristics.

Indeed, I do not think we could do better than approach the problem of the classical termination by considering what happens in those analyses which terminate for some extraneous reason. One of the most severe cases I ever treated, a drug addict with slight paranoidal trends and a number of distressing anxiety-symptoms, made a slow but almost uninterrupted recovery up to a point. His anxiety-symptoms had practically disappeared, his attitude to men was changed, his drug habit had after fractional deprivation been brought to the final absolute privation undertaken voluntarily; from being incapable of sustained business effort, he had applied himself to the extent of making a small fortune; all the prospects in fact seemed of the rosiest when at the critical moment he was discovered to have a sub-acute form of diabetes. This not only interrupted the actual analysis for various intervals but, as far as I can see, brought the whole curative process to a standstill. Death actually stared him in the face: here was something which justified the anxieties pertaining to his unresolved castration elements. The economic bargain he struck was then something like this: he endeavoured to reanimate the old anxiety-symptoms, but was unable to do so satisfactorily, partly because of the previous process of resolution, and partly because he had a better card up his sleeve. As can be understood, his paranoidal tendencies returned to some extent; they had not been subjected to the final analysis after drug deprivation. Most illuminating was the regressive change in his phantasy-preoccupations and in the nature of his transference, which in so far as it represented object-relations, took on an increasingly infantile colour. Some of these regressions were once more amenable to analysis but, as his homosexual defences to the positive Œdipus situation had not been completely worked through, he could neither regress completely to the mother-son position nor permit himself to exploit the homosexual element in the transference. So he checkmated further approach by regressing to an earlier form of drug addiction, using the hypodermic method instead of taking the drug by mouth and employing quantities which, although not so large as his pre-analytic habit, were greater than before the deprivation. This was to a certain extent overcome by continued analysis, but an exacerbation of organic symptoms followed, and the analysis was broken off at this point.

Another less eventful case may serve to illustrate what frequently occurs in analytic practice. A male with manifest passive homosexual tendencies came to analysis because of certain difficulties in his love-relations. As was to be expected, the conflict was quickly transferred to the analytic situation where amenability and submissiveness cloaked intense hostility-reactions. In course of time his castration-anxiety lessened sufficiently to permit of heterosexual relations of a fairly satisfactory kind. Now the point of immediate interest was that his analysis had to be limited by external necessities to the period of one year, and at first it seemed likely that apart from any symptomatic improvement he would continue the fundamental conflict at the transference level, that he would as it were see the thing through without loss. In fact the recovery of memories was practically limited to the first half of analysis and the main work was of a reconstructive nature. Towards the end of nine months it was possible to bring about some conviction about the significance of his transference-struggle, but even then it seemed that this would be continued without further resolution up to the last moment. This was partly the outcome, but nevertheless during the last three months typical terminal reactions were shown. Regressive homosexual images and interests returned, accompanied by an increase in masturbatory desires and phantasies. This was an attempt to cancel out what new adaptations had been made, but again the main regressive activities were shown at the transference level. He tried hard to get me to make various suggestions regarding his future mode and conduct of life, the result of which would have been not only to defend himself against further adaptation, but to keep him in a passive relationship to myself. He also played with the idea of continuing his analysis ; in short, he unconsciously laid plans and made dispositions for safety, and the analysis during the last three months, though superficially unaltered, was dynamically quite changed. The same interpretative work continued at the transference level, i.e. persistent reconstruction ; but concurrently the change in libido-dispositions, regression, etc., had to be made clear up to the last day.

A third example from everyday practice. A passive homosexual man with anxiety-symptoms and beating-phantasies came for a limited period on account of emotional upset and lack of working capacity. He quickly regretted the precipitancy of his decision to be analysed and, after preliminary improvement, including freedom from partial impotence, he endeavoured to divert the current of his libido into

extra-analytical channels. Headed off from this, he accentuated his transference-manifestations in the negative direction, and took advantage of the limited time available to lay plans for the future. Whilst amenable to any suggestion of delay in decision, he, like other patients, made dispositions for future safety. His ultimate decision was not affected, and after observing a suggested period of post-analytic delay he married a love-object who seemed to offer a compromise between his homosexual and heterosexual requirements.

My object in bringing forward these examples is to indicate that *even in so-called incomplete cases the end of analysis has more or less characteristic movements.* These are mainly of a regressional order, and involve the whole of the analytic material, symptoms, dreams, phantasies, transferences and extra-analytical preoccupations and activities. On the whole, they are most easily detected in the transference and in extra-analytical plans and activities. The degree of distribution in the latter case depends on the extent to which the infantile neurosis has been brought into analysis. If in spite of the limited period available the infantile neurosis has been largely uncovered, regressional movements will be exhibited mostly in transference manifestations. If for some reason or another the transference situation has never been fully charged up or expanded in analysis, the final movements will tend to involve reality to a relatively greater extent, e.g. the patient will openly toy with ideas of marriage, or with various changes in the libidinal *milieu* to be put into effect when he has ' regained freedom '. An interesting compromise is shewn where in the available time the transference has been expanded and already partly analysed ; phantasy will then be found to turn to the prospects of renewing analysis at some future date. In short, our experience with cases which pass through the initial difficulties of analysis but are later on discontinued for some external reason or prearrangement goes to show that characteristic terminal movements exist and that we are justified in mapping out roughly a terminal phase ; and, moreover, as was suggested above, that many cases are brought to a termination prematurely owing to a protracted second phase. This is especially true of patients whose transference-neurosis has been slighted in favour of direct historical reconstruction.

Now in the discussion of the transference-neurosis we limited ourselves for practical reasons to a clinical review of the situation and its analytic handling. Nevertheless, it is impossible to get the terminal phase into proper perspective without some additional reference to

the dynamics of transference. I have other reasons for taking this course ; in the discussion of resistance we were forced to regard the transference as a specialized ego-resistance calculated to limit memory, and, although in discussing the transference-neurosis we modified this to the extent that transference-phenomena also represent material which cannot otherwise be remembered, the impression may have been created that transference is, more or less, a defensive phenomenon. Any such view would be out of keeping with the facts. For one reason we know that, whilst the transference-neurosis is a situation produced artificially in analysis, the phenomena of transference are to be observed in all human relationships. Even without specific analytical observations, we could say from study of general transference-relationships that these must be connected with the compulsion to repeat. We see, for instance, how situations are repeated which are governed by some earlier principle than the pleasure-principle ; how, for example, a traumatic situation is repeated over and over and is only secondarily modified to satisfy the pleasure-principle. A similar tendency has been remarked on in the case of id-resistances, where a set of analytic presentations continues to arise for some time after the ego-resistances to these presentations have been reduced.

Now the specific factors in the analytic situation which modify the phenomena of transference into a transference-neurosis are twofold. First of all, the analytic situation itself is especially favourable to the development of an infantile attitude ; the patient has in one direction all the security and protection of the analytic room, complete lien on the attention of another human being, whilst the censorious parental factor is eliminated. Again, the early interpretative work, loosening of defences against repressed presentations, has set free a varying amount of libidinal cathexis, which immediately seeks to bind itself in ideas having reference to the analyst. But we must remember that in the neurotic patient we have already an abnormal intensity of charge. Why ? Because owing to some element of libido-privation, libido has already regressively reanimated unconscious phantasy ; it has attached itself to different levels of phantasy in accordance with specific fixation, and the outbreak of the neurosis was already a sign that ordinary repression (defence) was inadequate to deal with this hyper-cathexis. So the more effectively we interpret, the greater the charge we attach to ourselves. If we release more than a certain amount, we find all sorts of transitory symptoms appearing to deal with the surplus, and when we analyse these transitory symptoms we find behind them a

transference-phantasy. A patient with digestive disturbances will develop slight exacerbations, e.g. nausea, but you will find that these exacerbations are connected with some increase in phantasy relating to the transference.

At this point we may begin to tackle one of the questions which usually gives rise to difficulty regarding the terminal phase: *how is one to know that the time is ripe for termination, what indications exist by which one can settle one's policy?*

At the beginning of this lecture I suggested that the terminal phase of analysis distinguishes analytic method from all other methods of treatment, on the general grounds that the analyst does what no other therapist attempts, namely, dissolves the transference. We have now an opportunity of showing that *in arriving at a decision as to the advisability of terminating an analysis, he is guided by criteria which are more broadly based than those of the general clinician.* When a general practitioner treats a woman suffering from neuritis which he regards as of toxic origin, he is usually satisfied if the neuritis disappears. A more exacting colleague would probably postpone satisfaction till he was content with the state of the teeth, etc., etc., i.e. with alleged sources of toxæmia. A subsequent amenorrhœa would probably be treated on its organic merits as a distinct ailment, but if later on the lady sought for divorce it would not occur to the physicians concerned that they had been guilty of gross professional negligence. Yet this possible sequence (i.e. neuritis, amenorrhœa, divorce) could have been predicted with ease by any diagnostician who could relate anxiety-neurosis and hysteria to impotence on the part of the husband. We need not pursue this matter further: the illustration will serve to show that *the criteria for terminating analysis cannot be limited to symptomatic considerations.* Nevertheless, hospital traditions die hard, and it may be well to consider here and now what part the symptom-picture plays in arriving at a decision.

Now by the time we begin to canvass possibilities of terminating analysis, we have already gathered a fair amount of information about the symptom-picture. We know, for example, that in the first impetus of analysis quite marked improvement in the symptoms may occur. Again, as we have shown to-night, towards the end of the analysis, old symptoms may be revived. Moreover, during the transference-neurosis we are accustomed to see every variety of exacerbation of original symptoms, many fresh formations, and innumerable transitory formations. Each of these changes has to be valued in accordance

with the analytic situation at the time, and compared with other observations to which we will refer later. However, we might mention here some quite striking observations which can be made in certain analyses. In the analysis of depressive cases, we are glad to note the occurrence of obsessional symptoms, in obsessional cases we welcome the appearance of anxiety-attacks or conversion symptoms ; in hysteria we are pleased to observe that a seemingly uninhibited psychosexual life has been temporarily obstructed by varying degrees of impotence or frigidity. In perversions, criminal and character cases we may find that either obsessional or anxiety symptoms appear. À propos we must pay particular attention to any regressive symptoms, and in the case of mild disturbances akin to some psychotic mechanism, consider how far we shall be able to cope with them. Attitudes of suspicion, sensitiveness to observation, transference-reactions of delusional strength, hallucinatory types of association have all to be valued up in this connection. But to come back to the assessment of symptoms in relation to the termination of analyses. First of all, we have our own estimate of the symptom-picture as it has been presented to us during consultation or as it has unfolded itself during the first phase of analysis. I take it that we have already drawn some legitimate deductions about the depth of fixations and the extent of regressions which have soon after been checked by observation of analytic material. So that we are in a position to value whatever changes in that picture occur during analysis. We have kept a rough tally of the incidence of transitory symptoms, their frequency, intensity or specific quality ; moreover, in the later part of the transference-neurosis, i.e. when we have been satisfied that the transference-neurosis shows no very obvious gap in transference-dramatization, we have kept a sharp outlook for *signs of affective drainage of symptoms*. You will recall that what is true of analytic technique in general is also true in reference to symptoms, viz. that the most important indications are by no means the most obvious. In fact, we often wake up to find that only the husk of symptom-formation is before us. But, as I have said, we do not depend on this symptom-assessment alone ; in fact if we went by that sole indication we should often find that the patient could snatch success from our hands, and in any case, we must be prepared for reactivation of symptoms in the final regression. But the point of view I have presented is typical of the *method* whereby we can arrive at some conclusion about the termination.

Before leaving the subject for the moment, I must draw your

attention to the fact that I have omitted one most important consideration, viz. the methods by which we may legitimately test the strength of symptom-formations and incidentally forward the purposes of analysis. I have omitted to say anything about the imposition of abstinence rules or symptom tests. This subject will engage our attention throughout the next lecture ; in the meantime I will merely indicate that these comprise (1) general dispositions to prevent libido-leakage, and (2) measures whereby phobia cases at certain points are induced to face anxiety. I am not concerned here with principles, but I think you will see that the most favourable moments for applying the first set is when the transference-neurosis threatens to be drained by external leakage, and the best time for the second is when we have reason to believe that the symptom is becoming something of a husk, or more accurately a red herring.

Before proceeding further it will be well to review our position. We started from the assumption of a terminal phase, described some characteristic features of this stage, hinted that its initiation lay within the discretion of the analyst, and committed ourselves to furnishing criteria with the help of which we could arrive at the decision to initiate termination. We have shown that the usual symptom-standards are especially inadequate in psycho-analytic treatment, where symptoms are not merely measures of ill-health, but pawns in the game of autoplastic adaptation to instinctual demands (e.g. adaptation through illness). We have nevertheless investigated the symptom-factor in order to illustrate the method of appraising terminal criteria, and have hinted that in any case it may be necessary to apply some symptom-tests, on the grounds that the symptom-barometer gives a false reading until the glass is tapped. We are therefore left with the conclusion that symptom-assessment is merely one confirmatory measure among many possible. What then is the true analytic criterion ?

At this point we must return once more to the transference-neurosis. As you will remember, in the last lecture I pointed out that we had to deal with transference-manifestations from two points of view : (1) in so far as they enabled us to reconstruct infantile *libido*-development, and (2) in so far as they enabled us by means of transference-resistances to analyse the *infantile ego's* original fears, i.e. objections to these infantile tendencies. Now we have seen that the essence of the transference is an infantile relationship in which the analyst is identified in a composite way with the parental imagos ; in

fact we are reproducing a situation which existed before the patient dealt with his Œdipus situation by introjecting these imagos in the decisive mould of the super-ego. This fact, together with the tendency to recapitulation fostered by free association, makes it easy for the patient to regress to a ' pre-ideal ' state ; in other words, the identification of the analyst with the parent permits a regression in which the analyst is identified with the patient's super-ego. From the analyst's point of view this is in some ways a good move. The analyst is in important respects, such as absence of criticism, etc., a different person from the parent ; hence this identification permits of some modification of the patient's super-ego—of a fresh introjection which no longer says ' Thou shalt ' or ' Thou shalt not ', but *implies* the new adaptation attitude : ' Know your impulses and your environmental possibilities of gratification '. On the other hand, the patient's identification of the analyst with his super-ego is from the defensive point of view an even better move, one which provides the greatest difficulty for the analyst. By means of this identification the patient is able to turn on the analyst with all the hostility he once felt towards his own parents ; he criticises them (through the analyst) directly for their shortcomings, and in so doing disguises the fact that he is at the same time projecting on to the analyst criticism of his *own* shortcomings (i.e. playing super-ego himself and treating his own ego like an Aunt Sally, in the person of the analyst). Thus he is actually dramatising a regression ; the analyst is for him no longer a neutral object, but part of himself ; he has for the time being defeated analysis by narcissistic regression. In so far as he treats the analyst as an object, he says, ' Love me—give me what I want ' ; by the regression he implies ' Oh, very well—then I'll do it, myself, through you '. Now the hypnotist gains considerable therapeutic advantage by giving in to the demands of his patient ; he says in effect, ' I'll always love you if you get better ', whilst the patient says ' Good ' ; but he compensates himself for that abandonment of repressed allo-erotic impulses necessary for getting better by the regression to narcissistic relations. He treats the hypnotist not as an object, but as his super-ego. This is the hypnotic pact. The analyst, however, can make no such bargain ; he can neither gratify his patient's love demands nor can he permit the patient to turn the tables on him by a permanent narcissistic regression. If he took the former course, even if only by way of abandoning interpretation in favour of advice, his patient's improvement would, in so far as it was not due to earlier interpretation, depend on the frequent renewing of

personal relations ; if he permitted regression to be established, the analysis would be broken off more likely than not in a negative phase of feeling.

We have at last come to the crucial test of analytic progress.

It depends on the degree in which we have fulfilled the twofold requirements of transference-analysis, i.e. libido-analysis and ego-analysis. Both of these requirements are difficult to fulfil, especially the analysis of archaic instinctual demands and primitive ego reactions. It is possible that our familiarity with unconscious phantasy products makes us regard these as being easier to handle than ego-formations. It is certainly easy to start direct interpretation of infantile libidinal demands, and we can carry it a stage further at the beginning of the transference-neurosis. But this is not enough : our interpretations must be both deep and exhaustive. Take, for example, infantile sexual theories : we cannot rest until we are reasonably certain that we have *exhausted* these theories and linked them up with the most primitive forms of instinctual expression. Even then our work is only half done ; no analysis is ready for classical termination until ego-analysis is far advanced. The patient must have made the regressive identification already referred to of analyst with super-ego : he must have worked it through and he must, abating his demands on analytic protection, be ready to permit a modified super-ego to function in his own mind. *When the analyst feels that these conditions have been satisfactorily approximated to, he may, judging the tempo of the patient's mental adaptation, indicate that the time is approaching for the termination of analysis.* He is thereby giving warning of the approaching test of his labours, viz. the way in which the patient will stand libido-weaning, and he will not be surprised when even this preliminary hint arouses a storm of resistance, accompanied by regressive images and (or) exacerbation of symptoms. Before leaving this subject to deal with further practical considerations, let me take this opportunity of answering more fully a question frequently propounded, ' What happens if one neglects to analyse the transference adequately ? ' Primarily, of course, it depends on the stage of the patient's fixation and the accentuation of positive or negative elements of the transference. If the negative elements are accentuated it will mean, sooner or later, the permanent rupture of analytic relations : if the positive elements predominate it will mean an analysis ended in the second stage to be followed by exploitation of various devices for maintaining an extra-analytical transference, e.g. correspondence or occasional interviews.

In both instances, be it noted, there may be a considerable amount of permanent improvement in accordance with the amount of really effective libido- and ego-analysis which has been done. The case breaking off in a positive attitude will probably laud the analyst to the skies and send him vicarious sacrifices of new patients; the case breaking off in a negative phase may be very much better than before, but will return thanks for this amount of permanent improvement by sending cases to other analysts.

Having formulated the crucial test which must be applied before initiating the terminal stage of analysis, we may now return to some immediate practical details. It might be said, for example, that if this is the real test, it is surely advisable to have before us *confirmatory evidence*, in order to prevent any miscarriages of judgement due to impatience or boredom or optimism on the analyst's part. There can be no question that some safeguards are essential, and fortunately the nature of analysis makes it easy to establish these. As has been frequently emphasized, analysis is a dynamic situation charged with instinctual energy, and consequently includes within its scope a wide range of dynamic reactions. Moreover, at all points in analysis we are very chary of proceeding on the strength of a single series of reactions. For example, when we recognize a characteristic theme illustrated in the associative material, we are always on the alert to check this in various ways. We note the usual association signs, slips, pauses, reactions, etc.; if we have dream material to analyse, we observe this very carefully to see if it tallies with or opposes the conscious drift; we examine the transference relationship to see what particular personal reactions accompany this drift; we are interested to hear what sort of current social reactions are being manifested, *in fact, we get into the habit of assembling data from every possible quarter.*

We have already dealt with the penultimate assessment of symptoms and may go on immediately to the subject of *dream*-interpretation. There are many published analytical records in which we can study the importance of dream-observations in relation to analytic progress. I shall therefore confine myself here to two points. First of all, there are certain recurring dreams, any modification of which is often extremely significant. When a patient who all his life has had recurring anxiety-dreams of being chased by several gigantic and terrible bulls, happens to report after a considerable interval that the bulls are now simply ordinary-sized bulls, we are entitled, other evidence being favourable, to conclude that some fundamental improve-

ment has occurred. When an impotent patient with motor-car dreams, in which he cannot drive the car, reports consistently that he can now in dreams engage gears without much difficulty, we may draw a similar conclusion. Again, there are certain dreams which indicate definite crises in the conflict between infantile libido-demands and infantile ego-repudiation, dreams in which thinly veiled Œdipus castration scenes are strikingly represented and which are followed by various indications of altered reaction on the patient's part. These usually occur towards the end of the transference-neurosis after prolonged analytic labour. By way of practice in this later dream-assessment, I would strongly recommend careful study of the relation between dreams and the analytic situation in the first phase of analysis. At this stage we have done little or nothing to disturb the picture by interpretation, and we are often able to follow for a few months the constant reflection of dream situations in analysis and the manipulation of the manifest content of dreams to include analytic reactions. The subject is one which deserves more detailed consideration, but I am compelled to leave it with the general remarks: (1) that we are legitimately influenced by dream-material in considering the stage of analysis, (2) that in difficult second stages we can confirm the existence of transference regressions by reference to dream-material, and (3) that where we are in doubt about the patient's capacity to stand further analysis, i.e. in narcissistic neuroses, the dreams will give us timely hints of approaching difficulty.

It is an easy step from the consideration of dreams to that of *screen-memories*. In the earlier stages of analysis we are given a selection of memories of childhood, some of which begin to assume increasing importance. They are frequently recalled, but as a rule their content does not seem to justify constant recapitulation. I say as a rule, because on occasion we find *traumatic* events acting as screens for earlier experiences and phantasies. The point is, however, that as analysis continues these screen-memories begin to expand and take shape like Japanese flowers in a glass of water. One patient constantly recalls the vague outline of a cupboard and later associates it with a punishment of some sort; still later it transpires that the punishment was for a sexual offence against a younger sister; gradually all the details are expanded, but the cupboard keeps coming back, partly connected with homosexual phantasies, but ultimately as a cover for earlier experiences with an elder sister, behind which again are open incest phantasies. Another patient constantly visualises a couch.

In time this screen-picture expands into a kaleidoscopic image of numerous couches ; some of these can be distinguished and dated as real memories, associated with a network of phantasy, whilst others simply function as shorthand for unconscious phantasy. Each one of these elements has to be examined and interpreted before the couch picture finally decomposes and vanishes like the Cheshire cat. A third patient retains a vivid memory of seeing a pig killed, and in due course a multitude of pig memories have to be disentangled, a process which leads to the discovery of a delusion of having been born a castrated pig, i.e. an intra-uterine incest phantasy. Without going further into this matter, we may formulate the general statement that the presence or absence of unresolved screen-memories is a factor to be considered in fixing terminal policies.

Closely connected with the subject of screen-memories and their elaboration is the *expansion of infantile sexual theories* and their relation to primal scenes. It has already been suggested that an exhaustive survey of infantile sexual theory is essential. But it may be asked : how does one know when a survey is exhaustive ? Theoretically, of course, it is a simple matter to estimate this. Commencing analysts are not slow to observe that, for example, no vestige of anal material has ever made its appearance. With increasing experience less obvious lacunæ can also be detected. But, of course, the real test here, as elsewhere, is the nature of the patient's resistances.

We have now considered the symptom-picture, dream-material, screen-memories and infantile theories, and I will merely indicate some other factors to be considered. Closely associated with the symptom-picture is the nature of whatever *psycho-sexual* activities come under our notice. This is, of course, subject to the same qualification as that applied to symptomatic improvement, viz. that it must be taken in conjunction with other observations. We know that, like symptoms, various psycho-sexual inhibitions can be played off against the analyst at various stages. Less obtrusive, but often more significant, are the *changes in social reactions*, which can often be observed in the analysis and echoes of which are often heard in the reports of external relations with friends, authorities, etc. An alcoholic will come in at first in a shrinking, suspicious and furtive manner, and only gradually will you observe that he is beginning to march in boldly ; or you will learn by accident that he has for the first time in his life been able to take an independent attitude to some authoritative person of the same sex. Incidentally, you would not necessarily conclude in the latter event

that his analysis was approaching its termination. You would expect to find that after this external change, his transference-resistances would increase, e.g. that there would be a recrudescence of furtiveness associated with yourself. But, if you had worked through this transference repetition and reduced the second furtiveness, you would be quite entitled to include this change amongst the legitimate observations having some bearing on the termination of analysis.

To make a long story short, these are a few samples of the safeguards in our possession by which we can correct a too sanguine view of the progress of analysis. Incidentally, they also function as safeguards to prevent our being held up by repetitive phenomena. A case of frigidity may still continue to cry castration at the top of her voice, but if we find that her genital sensations have changed from occasional rending pains to admit sometimes (e.g. during dreams) of pleasurable genital sensations, we are entitled to take a different view of her case from formerly. We shall then watch rather carefully the extent of her reactions at the next menstrual period in order to check this observation. *What I want to emphasize more particularly here is our attitude to the situation as a whole.* During the greater part of analysis we are busy with actual analytic work, but without knowing it *we are mobilizing impressions.* When we decide to recommend analysis to anyone, we consciously mobilize previous impressions and experiences, and when we decide to terminate the analysis we again review the situation on the basis of all previous impressions, plus the immediate impressions formed during the analysis in question.

But, as with the recommendation to commence analysis, we do not commit ourselves about time-factors concerning which we are uncertain. On consultation, when we are in doubt about the suitability of a case, we usually recommend a short probationary period of analytic observation, varying from three to six weeks ; and this attitude of caution is even more essential when terminating analysis. Here one can only give the result of personal experience without in any way laying down technical rules. There are usually two sorts of situation to meet. One is comparatively simple. We suggest at some appropriate time that it will not be necessary to carry on the analysis very much longer. The patient, without going into the matter farther, immediately reacts to this hint, and we have an opportunity in the next few weeks of testing the actual strength of the regression. If at the end of that time we hold to our original opinion, we set a period for termination. If we find cause to change our opinion, we have not

been committed to an arbitrary period. On the other hand, the patient may immediately ask us for actual dates, in which case we can reasonably promise him an actual decision within a given period. In either instance, the patient will at once set to work to prove that he is unable to exist without analysis, but if we have given ourselves a margin for observation, we have time to make a reasonable decision as to the amount of ' playing-up ' manifested. Moreover, in either case we are in a better position than if we set an arbitrary period forthwith.

Having then given our preliminary hint, or suggested the necessity for a decision in the near future as to terminating, the time passes and we are faced with indicating the actual period. How has this period to be determined ? Well, first of all, what do we expect to happen in this terminal phase ? Briefly, we expect to initiate a phase of libido-weaning, a phase during which the ego will have to learn to take over direct control of instinctual life ; we expect that regressive symptoms will present themselves and that the ego will regress to still earlier levels. The threatened analytic separation will reactivate the oldest of all danger situations, separation from the mother, and the ego will go any length it can to cancel out this threat of danger. So we shall expect anxiety-symptoms and phantasies of the intra-uterine type. These symptoms will have to be examined and these regressions reversed before the terminal stage is complete. How long will this process take ? Now the rule here is that there is no rule. We have to depend entirely on our knowledge of the particular patient and his analytic tempo. But we have in fact quite a lot of information on this point. We know how long the initial phase lasted, i.e. from the commencement of analysis up to the time when we were certain that the transference-neurosis had commenced ; we know what period elapsed before the first improvement of symptoms was manifested, how long before the exacerbations of symptoms occurred, how long it took to deal with these exacerbations. We know how long the transference-neurosis lasted, how long it took to produce effective reconstruction, and how long it took to master the regressive phase of super ego identification. So we really ought to be able to estimate with reasonable accuracy the necessary duration of the terminal phase. The error, if any, is usually on the side of suggesting too short a period, so that it is well not to underestimate but rather to add a margin to our reasonably based expectations. In any case, I should suggest that at the least an interval of three months be allowed, and this mostly for anxiety cases. Certain obsessionals may need at least six

to nine months or over, and a narcissistic neurosis may require a year's foreknowledge that the analysis is definitely going to terminate. If for some reason your confidence should fail you at this point, I can do no more than recommend a study of the duration of some intractable organic disorders. When you have realized the matter-of-fact attitude with which, for example, a tuberculosis officer will embark on a fifth year of tuberculin injections, you will, I have no doubt, come to the conclusion that our estimates are not only modest but probably err on the side of optimism or inadequacy.

It will have occurred to you that up till now the whole of our attention has been turned to the preliminaries of the terminal phase. We have actually spent little or no time discussing the handling of the terminal phase. I trust, however, that in analysing the processes whereby we arrive at a decision we have at the same time indicated what part we shall have to play in the actual phase. We shall continue to apply the usual analytical rules and technique of interpretation, but we shall be on the outlook for different movements within the phase. For example, it is evident from the considerations we have brought forward that whilst the transference-neurosis is for purposes of convenience described as the second phase it is bound to overlap through a considerable portion of the final phase. Indeed, it is obviously impossible to complete the examination of the transference-neurosis until we have applied the touchstone of the terminal decision. In our earlier analysis of the narcissistic regression phase of the transference, we have been actively engaged in preparing the ground for the dissolution of the transference, and we must complete this work within the indicated period. But, as I have suggested, when we announce the termination we do not at first accelerate this process of dissolution ; on the contrary, we bring about an accentuation of the regression, driving the patient back to levels which are not capable of direct recovery. We may see our patients reduced to making inarticulate noises, beating the couch, crimping their toes and making uncoordinated movements. These we shall deal with by transference reconstruction. When this stage has been overcome we shall be on the outlook for plans and dispositions relating to future libido and ego obligations. These too we shall analyse in the same regressional sense, but the final precaution will only be suggested when the actual analysis has reached its termination. Remembering that the process of ego-adaptation will continue its impetus through a varying post-analytic period, we shall at the end of analysis point out the advisability

of continuing to observe voluntarily one of the recommendations we have made to the patient earlier in analysis; we recommend that he should not embark on important libidinal commitments or unwonted sublimatory drives until the lapse of an optimum interval. How prolonged that interval should be is a matter for the individual judgement, but I would again suggest a minimum period of three months for simpler cases.

On previous occasions I have suggested that whilst stages in analysis are useful concepts they must not be taken too formally. We are now able to say that there are only two occasions when we may act on the hypothesis of stages with relative certainty; the first is when we arrange for the commencement of analysis, and the second when we decide to initiate the terminal phase. On both of these occasions our own judgement is at stake. It is only in the classical forms of unmixed transference-neurosis that we have any opportunity of observing the more definite outlines of different stages. Even then, particularly with obsessional cases, the amount of overlapping is quite considerable. Hence I do not lay much stress on the practical value of affixing descriptive labels. I do not think it is important whether we call the latter part of analysis ego-education or libido-weaning: for one reason, at all stages of analysis both processes are operative. I do think it is important, however, that we should not aspire to accurate placing of patients in accordance with predetermined stages, but that, with an eye to the plasticity of mental mechanisms, we should at all points in the analysis deal with immediate situations with a mind as free as possible from preconceptions about some ideal course.

VII

'ACTIVE' THERAPY

I think perhaps the best approach to the subject of active therapy is to consider the significance of the term 'active'. You will remember that on several occasions, particularly when discussing resistances and the valuation of symptom-formations, it has been suggested that some technical devices come under the special heading of 'active' procedure. These rather mysterious references are liable to provoke some misapprehension in the minds of those who have not yet studied the historical development of psycho-analytic technique. After all, the reasonable comment might be made, 'If there are some emergency measures designed to meet situations of special difficulty, why not devote most of the available time to the exposition of these methods?': or 'Why bother about a roundabout technique if equally satisfactory and permanent results can be obtained by more direct methods?'

Now if we start from the descriptive and clinical point of view, the idea of active technique suggests some distinction from a previously existing 'passive' technique, although it does not necessarily imply that there were no 'active' elements in the passive technique. The 'active' elements might simply have been isolated from a passive technique, and elaborated into a fully-fledged 'active' method. Again, it might never have been intended to substitute an alternative procedure, but to use active measures as accessory devices, but here of course we again trip over a descriptive contrast between active and passive. Assuming then that some descriptive contrast is valid, we must go on to inquire whether this active technique is different in kind from passive technique, whether it has different theoretical implications, or again whether it is a *quantitative* rather than a *qualitative* factor which gives rise to the descriptive distinction. Having if possible decided this question, our next step is an investigation of the *aim* of active technique. Now the aim may be no different from that of psycho-analytic technique as previously understood, in which case 'active' technique would simply be an amplification of methods, filling up gaps in a previously incomplete and insufficient method. On

the other hand, it might be that active methods were introduced with a specific aim, e.g. to *shorten* the process of analysis, implying that, whether the original methods were satisfactory in other respects, at any rate they took up too much time. If now we were certain that the aim differed in some respect from the usual aim, our next obligation would be an examination of unconscious motivations, i.e. the subjective factor. This subjective examination would extend in two directions; if, for example, the method is intended to shorten analysis, we should have to consider two questions: (1) Why do we want to shorten analysis? Do the rational grounds account for the impulse, or are there any possible unconscious factors at work? (2) Have we any objections to the shortening of analysis? if so, are these entirely rational or reinforced by unconscious attitudes?

Having laid down these terms of reference, we are immediately faced with another terminological difficulty. We know that the phrase 'active' technique is in the psycho-analytic sense justly associated with the name of Ferenczi, yet there have been many individual suggestions made by other writers (cf. Reich's, that the recumbent attitude be at times abandoned for narcissistic types), which might be described as amplifications or modifications of the customary technique. We must therefore consider whether there is any dependable criterion by means of which we can assess all or any of these suggested methods.

I imagine we can clarify the issues a little by considering forthwith some of the points which do not depend on immediate clinical investigations. For example, we might begin with some consideration of *subjective factors*. This is a matter to which frequent reference has been made, especially in the last lecture, when we compared the psycho-analyst's attitude to the duration of analysis with that exhibited by fellow-practitioners in the treatment of organic disorder. Moreover, we do know from direct references to this subject that the idea of shortening treatment is one which exercises the mind of all analysts, starting with Freud himself. Freud has in fact turned over in his mind whether it might be possible, for convenience in treating numbers of needy patients, to combine psycho-analysis with some form of analytically-inspired suggestion; but he has always been careful to indicate that if this were feasible it would be a method to be sharply distinguished from that of pure psycho-analysis. Indeed, his most recent formulation on the subject of speed is that the quickest way of completing analysis is to stick closely to the proven technique. At any rate, we are justified in assuming that the subject of 'activity'

has a direct relation to the problem of shortening analysis. We can therefore with some fairness propound the usual question : Are there any unconscious tendencies which may influence us in favour of or against ' active ' technical devices ? In this connection we know that the analyst may react against thwarting of his therapeutic intentions, and, should he be unduly sensitive, will shew direct or indirect signs of impatience or aggression which might be rationalized as interest in active therapy. On the other hand, if he has retained to any degree the ' reaction-formation ' type of defence against aggression, he will be inclined to read into active technique a projected sadistic significance. He will then disguise this bias against ' active ' measures on theoretical grounds. In short, the activist's rationalization will be that it isn't necessary for analysis to take so much time ; the reply of the passive school will be that it is in the nature of things unavoidable. We are not immediately concerned with the reality-element present in such rationalizations ; the point I wish to emphasize here is that where decisions as to the validity of ' active ' measures have to be taken it is imperative for the analyst to examine himself carefully for any signs of counter-resistance. After all, we know how quickly during the transference-neurosis patients seize upon the analyst's attitude and endeavour to translate it into terms of unconscious phantasy, and, since counter-resistance is essentially due to the irruption into the analytic situation of the analyst's unconscious reactions, it is reasonable to assume that preferences and prejudices may exist in reference to modifications of technique, if and when the analyst is out of touch with some subjective motivations.

Another point may be considered forthwith : do we possess *satisfactory criteria* wherewith to estimate the significance of various departures from or modifications of the customary technique ? Now the technique of analysis as it has been described in these lectures so far is simply this : we bind the patient to follow the fundamental rule of association in order to have as free access as possible to unconscious content; we find that, in spite of preliminary progress, the access is more and more limited by resistances or defences : at the same time we discover that a special analytic situation develops, viz. the transference-neurosis, which if left unanalysed completely obstructs analytical approach, but which if analyzed gives us open access to unconscious material either directly or by way of reconstruction. In the handling of this transference-situation, the main strength of our position lies in the fact that whatever transference demands are made

on us, whatever *rôles* are ascribed to us, *we do not satisfy these demands or play these parts*. So I imagine classifications of analytic method might be related (*a*) to the interpretation of the patient's material and (*b*) to the maintenance of complete detachment on the analyst's part. With regard to the interpretation of material I think there could be little difficulty in laying down absolute standards. As Freud has said, psycho-analysis stands or falls by certain established findings, e.g. the facts of repression, of infantile sexuality, culminating in the Œdipus relation. I take it that any technique which endeavoured to get round these fundamental facts would automatically forfeit the right to be called psycho-analysis. For example, I have the impression that so far as the method has been described Rank's recent ' birth-technique ' will split on the rock of infantile sexuality, not that he repudiates the latter, but in so far as he minimizes its significance. Coming now to the maintenance of complete detachment on the analyst's part, we have seen that this enables us to induce conviction as to the repetitive nature of the transference-neurosis, hence that it helps us to reconstruct infantile development. *We realize that any transference-gratification tends to anchor the repetitive scene to the present day*. Moreover, since the repetitive scene is based essentially on repressed elements, the more we do gratify it, the more we provoke defences. Nevertheless it might be argued that if it were worth while, if there were no other possibility of progress, it might be justifiable to abandon our attitude of detachment and play at the appropriate time the part of an authoritative agent. This would not involve abandonment of any fundamental interpretation, and the analyst would be on the alert to defeat any increased tendency to transference fixation. Applying these considerations to the classification of active procedure, we can inquire whether these measures involve an abandonment of our detached attitude, *whether we do in fact at any time play the part of the super-ego ascribed to us by the patient.*

But first of all we must ask: Is it actually the case that in the customary analytic methods we do preserve *complete* detachment? It is immediately obvious that in certain respects we do not. For example, we are rarely content with the material given to us, but by interpretation imply that material exists which for some reason or another has not been presented to us. This is why the use of the term ' resistance ' provokes such resentment in patients: they react as if the analyst had said, ' Come along now, you little liar; what are you concealing? ' Actually when patients react in this way we know

that they are projecting an internal situation, viz. that the ego is feeling vaguely guilty, that the super-ego is taxing it with misdemeanours of which it is unaware. Coming back to the question of detachment in analysis, we have to admit that interpretation is not strictly detached, but, on the other hand, whatever the patient may think, *it is not an actual repetition of a parental attitude.* Again, when a patient comes late we do not remain detached; if need be we go out of our way to bring this fact into associative connections. Again the patient reacts as if we had said, 'You miserable little procrastinator, what do you mean by not coming when I told you to come?', and again we are able to investigate this repetitive reaction with a clear conscience; we have not in fact done more than bring the action into association. But occasions arise when the patient threatens to commit himself during analysis to important external policies; this being a risky procedure for the patient in his unanalysed state, and in any case a type of extra-analytical defence against analysis, it is our duty to point out that it is inadvisable to make such decisions during analysis. From the patient's point of view, this is at the worst a threat, 'Don't do that, or I'll not be answerable for the consequences', at the least a friendly hint, as if to say: 'Be guided by me, my boy'. In fact, whether the analyst is content with a simple suggestion or backs it with authority, he will usually find that his patient takes occasion to react to the situation in some typically infantile way, and he will be able to make some capital out of the analysis of such a reaction. Nevertheless, in a negative way *he has on this occasion abandoned neutrality* and has taken up a parental *rôle*, which the patient legitimately identifies with the prohibitive activities of his own super-ego, or, going further back, with the categorical forbiddings issued by his parents.

Now, although in the days before 'active' therapy was mooted as a more general policy the technique of analysis contained few elements of this kind, it did comprise two measures which were calculated to stimulate the patient's reaction. One was a rule of a prohibitive sort, viz. that analysis should be carried out in a state of abstinence, and the other a positive injunction that certain patients suffering from phobias should at a certain time begin to court rather than avoid the situation which induced anxiety. The former prohibition stimulated the patient at one of his most sensitive spots, i.e. his sensitiveness to frustration, and the latter injunction is identified with a parental command. It is therefore true to say that, in the usual analysis, there

are *isolated* occasions when the analyst abandons his attitude of neutrality and makes certain more or less binding suggestions to his patient, or, in other words, plays the part of parent or super-ego.

This would only be true of analysis from 1919 onwards, i.e. from the time when Freud gave the full sanction of his authority to these somewhat changed attitudes. Now, with regard to the phobia instruction, this was no new departure. In 1910 he had already made practically the same suggestion on grounds of expediency. Analysis, as he said, had been developed for the treatment of conversion-hysteria and required this modification to meet the necessities of anxiety-hysteria. In 1919 he made the original suggestion more stringent, and added that in obsessional neurosis, when the neurotic compulsion had been transferred sufficiently to the analysis, the new compulsion should be played off against the old one. But in this paper he was already influenced by the views of Ferenczi on active technique; so that his formulation on privation is a much more recent one and one, I imagine, which had far-reaching influence on subsequent investigations of active therapy. It would be well for us to note the exact indications Freud laid down on that occasion. First of all, the state of abstinence did not imply doing without any and every satisfaction. Secondly, it had to be related to the symptom-picture; *it had to keep alive the element of frustration*, the original trigger-impulse of the neurosis. When the patient had obtained some relief from his suffering we had to see that he did not obtain effective gratification by substitutive displacement in various activities, interests, pleasures, habits. These were to be energetically opposed by the analyst. So we see that there was little question of remaining detached throughout the analysis, but that the abandonment of neutrality was subject to certain checks, that frustration had to tally with the symptom-picture and did not mean simply sexual abstinence, in the popular sense of the word; it was directed at substitutions for symptoms.

It is only fair to add that from this time on a certain amount of confused counsel has existed on the whole subject of interference. This is due to the fact that Freud's pronouncements on activity were stimulated by the earliest of Ferenczi's papers, and that since then no authoritative opinions have been expressed other than the views brought forward by Ferenczi. It is true that in a recent paper on 'Lay Analysis' Freud made a somewhat disconcerting comment on the shortening of analysis: 'The best way to shorten analysis is to carry it out correctly'. But, apart from the fact that active methods

have been suggested not merely to shorten analysis, but in some cases as the only means of achieving successful analysis, there is no unanimity on the amount of interference which is included in ' correct ' analysis. The rules as to frustration are variously interpreted by analysts, and the manner in which they are applied varies from the most tentative suggestions to much more sweeping recommendations. In this connection it is instructive to note that a high percentage of the technical problems that are brought forward in analytical discussions relate to questions of analytical ' interference '.

At this point we must follow the development of ' active ' technique as suggested by Ferenczi. As the result of his investigations of some cases of hysteria, he formulated a new rule, viz. watchfulness for larval forms of masturbation giving cover to libido and possibly displacing the whole sexual activity. These forms were to be provisionally forbidden to prevent short-circuiting of pathogenic phantasies. Then followed his first general sketch of an ' active ' technique, which was doubtless stimulated in part by Freud's general support of the principle of frustration. Active technique now involved the activation and control not only of erotic tendencies, but also of highly sublimated activities. Two stages of the technique were indicated, viz. ' painful ' tasks followed by ' painful ' abstinences, commands by prohibitions. In the first stage repressed instinctual components are converted into conscious wish-formations, and in the second the awakened excitations are forced back to infantile situations and repetitions. Both stages induce privation, but it may only be necessary to forbid an existing activity. The technique must be used sparingly as an adjuvant, and only when the transference has become a compulsion. It is often indispensable in anxiety-hysteria and obsessional neurosis and has an especially suitable field in character-analysis. In this paper Ferenczi dallied slightly with a suggestion made by Freud, that with due precaution and in certain difficult cases it might be possible to use some slight pedagogic guidance, but on the main point his idea is simply to counter the pleasure-principle, in order to carry analysis forward. It increases resistance and conflict, hence should not be employed by beginners, or only with great precaution.

The next stage in the development of Ferenczi's views is to be found in his joint publication with Rank of the *Developmental Aims of Psycho-Analysis*. Here analysis is divided off into stages, in the first of which cathexis is withdrawn from advanced ego-positions (personality, neurosis), i.e. from ego-outposts, and is guided back to the

Œdipus situation and its fore-stages. The active interference required here ' need not go beyond that degree of parental authority existing in the transference '. The first stage leads to the establishment of the transference, at which point libido-resistances arise, owing to the patient's refusal to recognize the unattainability of transference demands. Explanations and translations are only a first resource, and the analyst ceases to be passive. In his own words, ' the physician then to a certain extent actually fills the *rôle* thrust upon him by the unconscious of the patient and by his flight tendencies '. We must do more than uncover an ' Œdipus complex ' or interpret its repetition in analysis: we must separate infantile libido from its fixation on the first object and occasionally take measures of activity (injunctions and prohibitions) ' to uncover traces ' of the Œdipus relation. When the time is ripe, the last phase of libido-weaning is accompanied by an active step of setting a fixed term to the analysis itself.

This brings us down to 1925, when Ferenczi published his *Psychoanalysis of Sexual Habits*. Starting from investigation of certain anal and urethral habits, as discovered in analysis and as subjected to his injunction-technique, e.g. the holding up of stools, etc., Ferenczi concludes that in this way we can open up otherwise impassable channels of communication between character-peculiarities and neurotic symptoms and between instinctual impulses and infantile development. These methods are therefore of special use in character-analyses. Moreover, he found that the child's identification with its parents has a *pregenital* preliminary stage of rivalry, which also sets up a severe sphincter-morality. Cases suitable for the method should evidence some displacement backwards of castration-fear to anal and urethral excretory function. Going on to the subject of sexual gratification, he modifies Freud's views on direct sexual abstinence; he regards it as unfavourable if patients can enjoy sexual pleasures during analysis. On the other hand, it is not essential to prevent gratification of onanism if this has been prevented by anxiety; if, however, toleration has been induced, complete abstinence must follow. He again emphasizes the importance of studying the patient's movements in analysis. Habit being intermediate between voluntary action and instinct, but nearer to instinct, he regards habit-analysis by his methods as ' analysis from below ', as distinct from the analysis of ego-reaction ' from above '. The latter is the classical method which should be adhered to until the patient begins to make himself ' at home ' in analysis. Then one should make an ' active ' start with the

patient's relationships to family, friends, colleagues, superiors, etc., going on to personal habits of eating, sleeping and physical gratifications. The analyst in special cases may use the instruments of friendliness and severity, chiefly in psychopathic cases. Habit-analysis is of less importance in hysteria, but obsessionals may benefit favourably. Then, as to the time-limit for analysis, the patient must have arrived at the stage where transference-resistances alone prevent conviction. A preliminary hint may be given of approaching termination.

In his last paper on 'Contra-indications to Activity', Ferenczi seeks to correct some critical impressions and, as the result of further experience, to modify some of his views. He admits that the patient's resistances are increased, that activity proves to be a disturbing or destroying agent of the transference; hence it should be avoided at the beginning, but is inevitable at the end, of analysis. He has, however, abandoned the method of 'ordering' and 'forbidding', but gains the patient's intellectual understanding first, and always leaves an avenue open for withdrawal in case of insuperable difficulty. In regard to the fixing of a termination, he has found that this may often miscarry, and he has modified his views on this point, but without giving us any very precise indications to follow.

By way of addition to his technique, he now suggests relaxation exercises directed against muscular tension, and refers to the active investigation of obscene words in cases of tic, stammering, obsessional neurosis, impotence and frigidity.

From this brief summary the most important conclusion to be drawn is that no settled policy has been arrived at, even by the originator of the method, and that we must wait a more systematic exposition from his pen. In practically one breath we are told that 'analysis from below' is in most cases essential, but that it may not be possible to pursue it successfully. This may well be so; anyhow the finding is one which in the meantime relieves all but research-analysts from the necessity to commit themselves to his *full* technique. On the other hand, it is equally certain that his methods have been amplified very much in recent years, and we cannot escape coming to some decision as to the extent to which we might legitimately use his privation and frustration technique. To take an extreme illustration, a Ferenczi analysis might imply that towards the middle of the second stage, or a little later, we proceeded to apply an increasingly vigorous series of frustration measures which did not stop short of the end of analysis. Compare this method with the suggestion made by Freud

that, guided by the patient's own attempts to displace, we should put obstacles in the way of displaced gratification and so reinduce frustration. In theory there is no essential difference between the analytic situations involved: they both imply playing the part ascribed to us by the patient's unconscious. Moreover, we can see that Ferenczi was logically following out the tendency thus countenanced by Freud. But in practice there are certain differences. The first is quantitative, that in Freud's method the amount of interference is much less; so much less that his technique is still regarded as passive when compared with the Ferenczi technique. The other difference is that Freud's method is limited by essentially clinical considerations; the frustration he wishes to maintain is roughly the amount which originally stimulated pathogenic reactions. Ferenczi, on the other hand, whilst relating his technique to states of stagnation in analysis, has recourse to measures calculated to produce frustration in a person who has shewn no clinical symptomatic reaction. In respect to habit-analysis, he goes 'all out' to uncover remainders of the original primitive pleasure-ego, which have, as it were, escaped the attention of later ego-institutions. As we know, these remainders are especially important in character-analyses, but they are also present in any normal individual, meaning by normal any one who is free from symptoms, unhampered by mental conflict, and shews satisfactory working capacity. In fact, it is arguable whether under existing civilization these pleasure-ego remainders do not contribute considerably to the mental balance of the 'ordinary' individual.

But, whilst in Freud's method more attention is paid to this question of the balance of frustration, Ferenczi's extensions may still claim to be regarded as *ad hoc* measures. This is a matter which can be decided only after more extensive investigation of unsuccessful analyses observed with each method; but in the meantime we can go on to consider whether Ferenczi's methods can be logically extended in other directions. We have seen that Ferenczi starts with the performance of certain activities within the analytic room, and on occasion does not stop short of permitting or inviting certain types of patients to strike him. Again, his interference with extra-analytical activities is very extensive, ranging from various bodily habits to all sorts of sublimations, and ultimately to complete control of the patient's psycho-sexual life. Many of the examples he cites are admittedly measures adopted in extreme cases, but, for my own part, I cannot see that there is any logical halting-place to the system, although certain

limits might well be imposed by empirical necessity. Where a patient, for example, combines strong exhibitionistic impulses, or their reaction-formations, with a combination of guilt and defiance relating to infantile auto-erotic manifestations, I cannot see any logical objection to the re-enactment of such scenes during the analytic session : they would certainly stimulate guilt and gratify hostility. And ultimately, if we may permit a ' sample ' attack to be carried out in analysis, there seems to be no logical reason why one should not countenance sexual aggression on the patient's part. Again, if we may as an analytical manœuvre hold up sexual gratification, there seems to be no logical reason why we should not introduce certain positive exercises in this direction. One has only to recall how in normal fore-pleasure certain elements may be over-inhibited, owing, for example, to contamination-phobias, to see that anxiety-positions might be stimulated by appropriate suggestions in this direction.

I have chosen here certain exaggerated examples because I think that we may in this way give point to a possible theoretical disadvantage inherent in active methods involving abandonment of neutrality. After all, apart from social considerations, why should we stop short of re-enactments of the kind just indicated ? The answer to this question is contained in Freud's description of the processes of repetition and working through. We are bound to allow the patient time and place in the transference neurosis to work through certain repetitive scenes, but all the while we endeavour to stem this repetition, to convert it where possible into the psychic work of remembering. I take it then that in certain ' active ' measures we are, however justifiably, encouraging the tendency to re-enactment. Now the more re-enactment we permit, the more we encourage ' anchoring ' to a present-day situation. The objection to an unanalysed transference is precisely that we unwittingly encourage a second fixation in the transference-neurosis. ' But,' the activist says, ' there is no danger if all the time we are aware of what we are doing and interpret the reactions produced down to the last vestige. Besides, we can't get on without it '. It may be so, but we shall have to wait for additional evidence from both sides before we are entitled to recommend the complete ' active ' method to commencing analysts or as a routine procedure to all analysts. In the meantime it has to be noted that, although Ferenczi is prepared to consider (as Freud too has been) the positive advantages in certain cases of a more friendly *attitude*, he has always been careful to say that we cannot at any time give way in

action to the patient's demand for fulfilment of positive transference demands. This is, for reasons we have indicated, a perfectly sound doctrine, but it does bring to the fore a problem concerning the use of active therapy in masochistic and passive homosexual types. For these an authoritative attitude is peculiarly significant, and might be regarded as a transference-gratification.

All that we have discussed so far has had reference to measures of activity which involve abandonment of neutrality on the analyst's part. We have said nothing of measures which although seemingly 'active', do not involve this abandonment of analytic neutrality. As an example of this sort we may choose Ferenczi's method of *forced phantasy*. Ferenczi has made many suggestions as to variation in the handling of associations, but one of the most striking was that applicable to patients with a seemingly impoverished phantasy-life. In such cases, in the later stages of analysis, he found it advisable to make the patient deliberately expand some idea which seemed to be the key to a phantasy. If he did not gain any result by this means, he would not hesitate to suggest himself the general lines the phantasy should have followed, and then insist on elaboration along these lines. The types of phantasy were, (*a*) positive and negative transference-phantasies, (*b*) infantile phantasies, and (*c*) onanistic phantasies. As such measures are really on all fours with interpretations, it seems to me that they are entirely legitimate, although naturally one should be chary of giving the broad lines of a repressed phantasy unless one is sure of one's ground. But, of course, the same qualification applies to any interpretation. With regard to the deliberate stimulation of phantasy, this is useful, not only in the later stages of analysis, but it can often be employed with effect in difficult first stages, although here it is done much more tentatively. Personally I am in favour of judicious use of the method at any of the difficult phases in analysis. This holds especially for transference difficulties. For example, when the patient, discussing say some course of action, suggests casually alternative plans, but dismisses one as irrational or unimportant, one can then legitimately say: 'Let us suppose for the moment that you took this course, what occurs to you on the subject?' The same policy may often be applied with advantage to a slip of the tongue, when the patient brings no spontaneous associations to the slip: the question can then be propounded, 'What do you imagine would have happened had such and such actually been the case?' Ferenczi has made many other suggestions of a valuable kind in reference to the use of the association-

rule, and certain interruptions which can be made with advantage, especially in the analysis of obsessional neuroses. These can be found in his volume of *Further Contributions* recently published in English.

This policy of paying meticulous attention to details of analysis, of going out of our way to produce phantasy-material, brings us back once more to consideration of really ' active ' therapy. I think it will be admitted that until Ferenczi drew our attention more closely to such details many of the previous passive analyses had erred on the side of being too passive, in the sense that many minor analytic manifestations had not been turned to legitimate advantage during treatment. It is true that slips and other similar indications were, as a rule, exhaustively analysed, but there was no *systematic policy* of investigating continually all sorts of silent indications, attitudes, gestures, movements, facial contortions, etc., at the time when these needed systematic attention. Now the question immediately arises, Had such systematic policies been pursued, would the number of stagnant analyses have been so great as to make the consideration of ' active ' measures quite so urgent a matter ? Is it possible that with more careful attention to detail in analysis coupled with more vigorous transference-interpretation, and on occasion employment of ' forced ' phantasy, we should be able to revise our estimates of difficult analyses, hence to avoid what are admitted by their author to be the difficulties of adopting ' active ' devices ? I think that this is more than probable. To take one example : in the section on transference-neurosis I pointed out that when this artificial neurosis is established every thought or action in the patient's analytical life or reference to thought and action in his extra-analytical life will be found to have some bearing on the transference. I also added that in most analyses difficulties arose when (owing most likely to some lack of conviction on our own part) we neglected to make sufficient capital out of these circumstances. Obviously then the time to turn these to advantage is during the second stage of analysis, and especially during the latter half ; but, as with the use of forced phantasy, it is often advantageous in difficult cases to use some of these methods quite early. Abraham long ago pointed out that in cases with intense unconscious hostility it is essential to make clear to the patient at the earliest moment the transference-significance of this hostility. But to return to the average case, I am strongly of the opinion that *faint-heartedness in making transference-interpretations is responsible for more stagnation in analysis than any other attitude.* I have previously given illustrations of the

accuracy of transference-interpretations of apparently trivial manifestations occurring during the analytic session, but I want to emphasize now that much legitimate activity is permissible in this direction. We know that, in the case of dream-interpretation, it is often advisable to jettison the greater part of a long dream-narrative, and to be content with fractional interpretation, and we know that Ferenczi, in cases of copious phantasies, often directs his patient to seize on one point where most guilt seems attached. In the same way it is often advisable when the transference-situation is over-congested not to wait for a prolonged train of associations, but to start transference-interpretation of a single phrase or attitude occurring at the beginning of the session (with or without guilt manifestations). This is especially valid in obsessional cases where the subject of the whole session's ruminations is already clearly indicated in the first few seconds. We need not, of course, make a habit of this, or indeed of any other policy in analysis, including 'active' measures, because as soon as the patient has grasped the new idea he immediately plays up to it and endeavours to fool us, casting associative bait at the beginning of each session. In general, however, this and similar policies may be pursued with advantage, especially the investigation of minor reactions to the analytical room, to noises heard and commented on, to household arrangements, the population of the waiting-room, the street, and so to the world at large. The point is, however, that we do not permit dwelling or anchoring on these subjects, but as soon as we are sure of our ground use any one detail to make a breach in the defensive rampart of transference-phantasy. Everything is grist to the mill, and everything that escapes the mill remains as a representative in consciousness of unconscious interests. Incidentally, in practising this technique, we are able to satisfy ourselves on numerous occasions as to the advantage of not mixing up reality-explanations with the consideration of transference-phantasies. When recently I changed my consulting-room, it became apparent that of the numerous problems which intrigued almost every patient the position of the water-closet had a distinct preference. On some occasions the matter was brought directly into analysis: where was the lavatory? In no case was any reality-comment made: the matter was followed up purely from the point of view of phantasy. In other instances the lavatory was briskly sought out and turned to regular use; this action was likewise investigated from the phantasy point of view. A third group made no reference to this important institution; needless to say, the individuals

concerned shewed other signs of repressed anal phantasy. Now, as we are dealing with the subject of ' active ' technique, we might inquire whether it would not be possible to extract some advantage from the fact that important phantasies are displaced to unimportant reflections on analytical furnishings. Why not keep a stock of more or less obviously stimulating objects calculated to attract the roving eye of infantile rumination ? Now, whilst such objects would certainly stimulate, they would not only stimulate infantile libidinal interest, but clinch a transference-phantasy and anchor it to reality, e.g. the phantasy that the analyst (i.e. the parent) was a born exhibitionist. In fact, the great advantage of not doing so is just that phantasies concerning conventional decorations, when uncovered, are productive of infinitely more conviction in respect to their displacement.

To come back, however, to the line of argument : it seems likely that if our scouring of the analytic situation and everything connected with it were more thorough, it might be possible to induce conviction without having to employ general measures of activity such as Ferenczi describes. On the other hand, this is a point concerning which Ferenczi is quite emphatic : he says that transference-interpretation and historical reconstruction are not enough to produce conviction, and we are bound to take cognizance of this weighty opinion. Assuming then that we must do something else to bring about conviction, how is it to be done ? Here we have to record the most remarkable change in Ferenczi's technique : from exercising the full strength of his personal authority, backed if need be by threat of discontinuance of analysis, his commands and prohibitions have become merely strong ' suggestions ', and are now prefaced by a process of obtaining the patient's intellectual assent. This is more a quantitative change than a qualitative one, because ultimately the reasoning and reasonable parent can provoke as much (sometimes more) infantile reaction as the rough-and-ready type. Nevertheless it is an important change and suggests the possibility that further modification is feasible. My own experience of calling attention in analysis to *any* external happening simply for the purpose of obtaining associations to that event is that patients frequently react as if they were being criticized ; moreover, in spite of the analysis of this infantile reaction, the next time that situation or a similar one arises, they make a point of altering their conduct in some respect. In a negative phase they will repeat the situation in a more pointed way, whereas in a positive phase they will modify it. You can produce reactions of this sort at any time by com-

menting on the smallest details of analytic behaviour. Tel a patient that his foot is resting on the floor, and depending on the nature of the transference, he will either lift it back hastily or plant it a shade more firmly on the ground ; on subsequent occasions the position of the foot will be found to have acquired enhanced significance.

These observations could, I imagine, be turned to advantage in dealing with situations where, for reasons of analytical 'drainage', some privation seems to be indicated. Suppose, for example, a patient suffering from partial impotence becomes involved in relationships of a promiscuous type, ostensibly in order to 'test' his progress or 'further' the analysis of his inhibitions. One could first call attention to the significance of these external situations historically, i.e. interpret them, then indicate their significance as a dynamic defence against analytic progress as a whole, or again point out their significance as transference-displacements. Assuming that the situations remain unchanged, we are not yet at the end of our tether ; we can call attention to the fact that, in spite of previous analysis, this type of defence *persists*. Finally, we can draw attention to the *possibility* of abandoning these defences and allow an interval for further analysis before directly suggesting the *advisability* and ultimately the *necessity* of taking this step. Moreover, it does not follow that, having once been reduced to authoritative recommendation, we should on any subsequent occasion for interference omit the intermediate steps. We can begin all over again, but of course proceed more rapidly along the series, i.e. allow less time for working through. *I would suggest then that we should persistently endeavour to get the expected advantages of active therapy without stepping aside more than is necessary from analytic neutrality. This would apply not only to external libidinal dispositions, but to the testing of symptom-formations and to the analysis of habits.* One comment, however, falls to be made : if for some reason or other, perhaps that we have under-analysed the transference or that the patient's instinctual drives get more compulsive expression than usual, the external situation piles up too quickly, we must simply recognize that the analysis is about to be jeopardized and take the risks of more immediate and emphatic recommendation.

But let us assume that the most difficult situation arises, that we are convinced of the necessity for active measures and that we cannot get round that necessity. What sort of general policy should we adopt? I take it that by this time we are well in the middle of the transference-neurosis, that there exists a dependable amount of posi-

tive transference or, what is a more reliable guide, that a good deal of negative transference has been ventilated. The next step is to choose the moment. Obviously it must be connected with some hitch or stagnant period, but it is equally necessary that no immediate transference-material should remain unventilated, e.g. that no increase in negative feeling should have occurred owing to our attempts to get through the difficult phase. When we are satisfied as to this and a temporary lull occurs we can then make our direct recommendations and prepare ourselves for the increased transference-reactions of a prevailing negative type which will ensue. But what is a stagnant period ? It is a period when a careful review of all analytic manifestations, associations, slips, transitory symptoms, symptom-picture, can shew no sign of progress, when there is nothing explosive to be observed at any point and when there is no increased defence at any point. When such a situation persists we may fairly diagnose stagnation.

It follows then that in preparing to adopt any form of activity in the systematic way suggested by Ferenczi we must take precautions similar to those which I indicated as being necessary before deciding that any analysis has reached the terminal phase. And this reminds me that in discussing the means by which we can check our impression that the end of an analysis is near I omitted any consideration of ways and means by which we can assess or test the state of symptom-formation. Also I have given no very precise indications as to application of these symptom-tests. I propose therefore to remedy these omissions by a brief review of a typical analytic situation. To go back then to the opening phase : it is clear that there is little scope here for any interference calculated to keep up the level of frustration. There has been no breaking down of fundamental defences, and the symptoms are still pressing. In difficult and refractory cases we may find ourselves compelled at the outset to be very active in the interpretative sense, but the only scope for active interference in the super-ego sense is where we believe that extra-analytical difficulties threaten to obstruct the analysis altogether. We may then point out that a specific situation, e.g. a very stimulating domestic environment, is an important obstacle to progress. In the ordinary way we should prefer to examine this situation through the analysis, but in difficult cases we may not be in a position to wait and may be compelled to indicate that some respite from this stimulating situation is necessary.

Coming back then to the ordinary case, where we have so far done

nothing very active, the first defences may have been reduced, symptoms may be alleviated at the end of the first stage and the transference-neurosis automatically established. Here we expect to see an attempt to sidetrack libido into external situations, and, provided we are unable to reduce this defence through the analysis itself, it may be necessary to make recommendations—only, however, if the success of the analysis is definitely threatened. As a rule we are able to deal with the situation through analytic discussion, in which case we proceed with transference-interpretation and historical reconstruction. Allowing suitable periods for working through difficulties, we arrive at the later stages of the transference-neurosis, where we are busy with analysis of infantile ego-attitudes. On this, as I have said, much of the effectiveness of the analysis will depend, and at this point it is convenient for us to have some more definite idea as to the real state of affairs. For one reason, it would be risky to be satisfied with the degree of ego-analysis attained if effective substitution of repressed impulses was taking place. Moreover, we want to know whether the symptom-formations which may be present are really depleted, whether, as I have said, they are mere husks behind which the ego takes shelter from the problems of new adaptation. At this point we can take the first convenient opportunity of getting the patient to face up to what have previously been stimulating positions. We shall thereby not only advance the analysis, but be able to take soundings as to the amount of work still to be done. Reviewing the second stage, then, we see that the first line of interference is related to *sidetracking*, and the second to the *heading-off of symptom-substitutions*, which at the same time enables us to check the strength of previous or existing symptom-formations and so ultimately arrive at a decision as to the length of analysis. So far we have followed the customary and accepted technique. If now, in spite of these measures, we find that difficulties remain and we cannot make progress, it is for each analyst to decide according to his experience and judgment whether he will adopt Ferenczi's system in part or in its entirety. If he does not favour the method, there is no alternative but to stick to his previous policy, paying redoubled attention to transference-phantasies until either he resolves these difficulties or external pressure comes to his aid and forces the patient to loosen his defensive grip to some extent. If he does follow Ferenczi at this point, he will be well advised to take constant stock of any tendencies to counter-resistance on his own part, and if he does succeed in getting things going, to retire immediately

to his customary neutrality until he is again forced into the super-ego *rôle.* Assuming then that the analysis moves and the second stage is advanced sufficiently, we may come to the conclusion that the end is in sight and proceed as suggested in the last lecture, remembering always that this decision as to termination has nothing to do with ' activity ' as such, and that it is arrived at as the result of a clinical review of the whole case. As I remarked before, the opportunity for observing these cases to a typical termination is much rarer than is imagined. As a rule external pressure contributes considerably to the shortening of the second and last stages.

Looking back over this lecture, I find that I have made no reference to methods suggested by others than Ferenczi. In fact, there are not many such, and they fall easily into the groupings we have indicated. But I have omitted two points of some interest : (1) how far we may be able to turn to advantage in adult analysis the findings of Melanie Klein on child-analysis, and (2) how far we can employ various devices involving a positive super-ego attitude on the part of the analyst, e.g. relaxations of technique, advisory or pedagogic guidance. The first point will be dealt with by Mrs. Klein in her lectures on child-analysis ; and as the second necessitates some consideration of ' borderline ' cases, it may be deferred to our next and last lecture.

VIII

ANALYTICAL CRISES AND EXCEPTIONAL CASES

In the earlier lectures I endeavoured to put before you the idea that psycho-analysis is essentially a labile psychic situation, initiated by the analyst, driven forward by the patient's instinctual forces and following a course which is more or less characteristic and is divisible into rough stages. Variations in individual analyses depend partly on the different types of modification these instincts have undergone or, in terms of ego-organization, on the different types of regulation which have been standardized by the patient's ego in course of development. But they also depend on the amount of charge which the analyst taps by means of his technical procedure, or, again in terms of ego-instances, the amount of regulation or dosage the analyst adopts. It has been suggested that the most valuable analytical sense is a sense of movement, and that many of the crises of analysis can be avoided or surmounted by cultivating this sense of movement, recognizing the signs of sluggishness or stagnation and the signs of overcharge or tension.

In regard to the recognition of approaching crises, it is well to resign ourselves to the fact that, with the best will in the world, the patient does not afford us any material assistance on these occasions. Throughout a large part of every analysis his defences are almost entirely automatic, in the sense that they are put into effect quite irrespective of conscious attitudes: consciousness is merely aware of the end-products of defence, although it may during their operation have experienced varied affects. Indeed, it is a satisfactory sign of progress in analysis when defensive reactions become more and more apparent, when the archaic machinery becomes more rickety and creaks in most of its joints. But during the automatic stages the patient's mental organization is entirely opportunist and shews a remarkable readiness to meet any of the dangerous emergencies which it scents out in the analytic situation. *To counter this readiness the analyst must develop a certain counter-readiness.* Unfortunately, the crises of analysis are not quite comparable with the crises of organic illness where a temperature may sky-rocket before death or collapse before convalescence. In their mode of onset they resemble rather those unobtrusive but fateful processes in organic affairs which can be recognized only by sharpened clinical sensibility or by minute laboratory investigation, e.g. a smell, or some turn in the hue of lips, a slackening of muscles, the discovery of chemical products in the blood or urine, or the result of bacteriological cultures. It is true that the crises in analysis may become extremely acute and exaggerated, but, unlike crises in organic illness, they make their appearance in unexpected quarters and at moments when we have been lulled into a sense of security and stability.

So the analyst must be ready for all emergencies, and in a typical case of conversion-hysteria he will find his resources amply taxed, although in fact the classical technique of analysis was developed to meet just this clinical condition. But, as we have seen, the therapeutic field of analysis has continued to extend its boundaries, and in spite of the fact that analytic technique has preserved the same line of approach to the region of the unconscious and that the key-positions of psycho-analytic teaching (e.g. the facts of infantile sexuality) have never been abandoned, it was inevitable that the method should undergo certain *ad hoc* modifications. The extent to which these have been so far standardized was our main concern during the last lecture. Again, we know that our analytic case-material is rarely typical; the classical transference-neuroses most often fall by the wayside, and the

more difficult types of case, being on the whole shirked by general psychotherapists, tend to preponderate on the analyst's list. This high percentage of difficult and refractory case-material, whilst ultimately to the good, has certain drawbacks. It is apt to discourage the commencing analyst or to induce callosities on his analytical perceptions. At the very least it confronts him at the beginning of his practice with the most complicated of analytic problems, and may force him to dally with technical expedients which are rarely necessary in the analysis of more downright neurotic states. For this reason I have devoted one lecture to so-called ' active ' procedure, and shall have occasion to return to the matter for purposes of orientation in analytic policy.

The obvious advantage of handling *some* exceptional cases quite soon is that it teaches us how to deal with the critical phases which sooner or later are bound to crop up in every analysis. In view of this fact, I suggest that we devote the present lecture in the main to consideration of exceptional cases rather than dissipate our energies on a mere catalogue of sundry crises. Before doing so, I would point out that the critical phases occurring during the analysis of simple neuroses can be regarded from two points of view, viz. their position in the sequence of analytical events and the nature of their manifestations. I have already commented on the appearance of a critical phase when the first impetus of analysis has died down or, alternatively, when the transference-neurosis is brewing. With regard to the clinical appearances of crises in general, I shall content myself with the barest mention of some extreme examples. In conversion-hysteria critical phases are manifested by an exacerbation of physical symptoms which may entirely prostrate the patient. Obviously, this manœuvre can be most successfully carried out when there is some organic element in the symptom-picture, e.g. fixation-hysteria. In anxiety-hysteria the sudden appearance of large quantities of free anxiety may cause an equally effective prostration; e.g., an agoraphobic may be unable to leave her room. In obsessional neurosis a fresh or rejuvenated set of ceremonials may eat up the analytic energies, a depressed case may ventilate suicidal preoccupations (or a hysteric threaten self-destruction). An active homosexual will plunge into agonies of remorse and guilt or dissipate his energies in moral quibbling (super-ego hyper-activity). A case of partial impotence will develop temporarily complete impotence, etc., etc. All these are, of course, positive manifestations which may threaten the success or continuance of analysis,

but, as has been suggested before, there are many characteristic negative signs, to say nothing of the appearance of mixed reactions.

Coming now to the study of *exceptional cases*, we are faced with the necessity of picking out representative samples from a heterogeneous assortment of material. The characteristic they have in common is the absence of pure neurotic formations. Either they have no very obvious symptoms to report, or the symptoms they describe suggest the existence of psychotic disturbance. Consider, for example, the *cases of emotional maladjustment* which so frequently come for analysis, and which so often prove in the long run exceedingly obstinate and refractory, or, in the customary phrase, shew a negative therapeutic reaction. A patient may relate that, in spite of an apparently uneventful childhood, everything began to go wrong in adolescence. Accentuated homosexual interests may have been manifested; the career adopted may have proved unsatisfactory; and the signs of maladjustment may have reached their climax when, after an unsatisfactory marital experience, the element of frustration became decisive. Temporary relief may have been obtained by divorce, but this is followed after a varying interval by a fresh entanglement leading ultimately to the same emotional impasse. Others may fight shy of separation, but complicate the situation by means of recurring infidelities or periodical regressions to homosexual experiences. Others may have fought shy of marriage and followed a repetitive policy of promiscuity of a prevailing heterosexual, homosexual or mixed type. In such instances, the processes of social adaptation are more profoundly upset. In still other instances, the psychosexual activities reported are of a strikingly pregenital type. A different group of patients come to analysis, not on account of psychosexual difficulties, the existence of which is often quite emphatically denied, but because of adaptation troubles which strike at the root of their working and earning capacity. Either they exhibit a decreased interest in or capacity for their profession, or they claim to have unimpaired capacity which somehow or other is thwarted by constantly recurring difficulties. The result in both instances is identical: they are faced with economic disaster which usually involves other members of the family or the circle of friends.

We need not amplify instances. What strikes one immediately is the compulsive nature of their emotional relations, the unsatisfactory situations in which they are involved and the fact that such patients, as a rule, consider themselves normal in every respect, and repudiate

beforehand any implication that they exhibit neurotic reactions. I have said that these so-called ' normals ' are, next to psychotics, the most difficult patients to analyse, and it may be worth considering why this should be so. Here our experience with the analyses of neuroses should stand us in good stead. We may remember that one of the most difficult resistances to wear down is that which Freud has called the ' resistance of the Id ' : this resistance is closely related to the repetition-compulsion. The obvious signs of compulsive repetition of emotionally unsatisfactory situations should therefore warn us that *such cases will require prolonged working through.* There is, however, another factor of extreme importance. In the discussion of transference-neurosis, we had occasion to note not only that a repetitive factor is at work, but that, when this artificial analytic neurosis threatens to develop, the patient seeks to minimize its significance or indeed to evade all conscious appreciation of the transference by diverting libido into extra-analytical channels. If this diversion is not prevented by some means or another, preferably by the technique of interpretation, the analysis is bound to be abortive. Any permanent improvement is simply due to the amount of effective release secured prior to the libido diversion, i.e. to the amount of effective super-ego modification attained and the extent to which phantasy charge has been reduced. *The emotionally maladjusted person has already exploited this defence to the full. He commences treatment in a situation which in an ordinary analysis we recognize as being fraught with peril.* In the third place, there is either directly or indirectly a punishment element to be observed in all of these external situations. As, however, the punishment seems to be one which is not self-inflicted and the patient regards himself as the victim of circumstances, we can see that another analytical situation has been anticipated. In the ' transference-neurosis ' we have observed that at a certain stage the analyst is put in the place of the patient's super-ego, and an attempt is made to force the analyst to act up to this *rôle,* e.g. to play the part of critic and aggressor. *The maladjusted case commences analysis with this projection in full swing.*

How then are we to deal with such cases ? The ' Id resistance ' can in itself be countered only by a sufficient working through in the transference, but the transference-defences are already doubly reinforced. So that, in addition to the usual analytic situations, *we must pay special attention to the system of libido-diversion and to the guilt-punishment system.* Incidentally, it is a commonplace that, whilst

such patients consider themselves symptom-free, it requires only the slightest attention to perceive that they suffer from many minor symptom-formations which have been obscured or minimized by the existence of grave emotional disturbance. They have, in fact, many anxiety-formations and a considerable number of obsessional characteristics. These symptoms are a godsend to the analyst: they provide numerous openings for the customary analytic procedure. But they must be carefully nursed, and there should be no systematic attempt to alleviate them. On the contrary, they serve as *transference-indicators, and our purpose should be to bring about their exacerbation.* Again, their alleged normal psychosexual life is sooner or later found to be interrupted by varying types of inhibition. Here again we have a situation which must be very fully and carefully exploited in the interests of analysis. To put the matter rather crudely, one of the signs that the case of maladjustment is making favourable progress is that he begins to form neurotic defences, i.e. turns ill.

Now, with regard to the external situation, we may learn much as to its analytical handling from experience of cases coming simply for consultation. We are all familiar with the homosexual types who come for consultation on account of emotional upset occurring at one or other of the periodical ' break-away ' movements in their series of relationships. They state quite frankly that their homosexual activities would be entirely satisfactory if only they did not get so upset when the periodical trauma occurs. They don't mind being analysed if they can be freed from this emotional disturbance, but they must have a guarantee that analysis will not affect their type of gratification, a guarantee which, needless to say, cannot be given. Other individuals arrive for consultation because of the same element of upset in love-life ; the difficulty is associated not only with their own reactions, but with the reactions of the object, who has certainly been chosen because of these specific qualities. Here again they demand a guarantee that nothing will affect the relationship itself. If such cases actually come to analysis *our efforts must be directed against the element of concealed gratification in these external situations.* At the earliest possible moment we must make this gratification-element clear. Now, as a rule, these patients have a simple way of avoiding the issue. They attempt to *isolate* it so as to preserve it from solution. They have come to analysis full of grief and misery, yet every time they approach the present-day situation we have the impression that they have not discharged a tithe of their pent-up emotion. Gradually we observe

that less and less reference is made to the subject, not merely because the analytic technique is leading to a diversion of interest, but lest the discharge of affect (apparently justified by present-day conditions) would exhaust the cathexis of the reality situation, and so lay bare its unconscious components. The opposite type of defence is seen where patients spend an inordinate amount of time in affective discharge, going into elaborate and explanatory detail, all of which is accompanied by profuse emotional reaction. In extreme instances this may go on for some months. Here we must not be misled by the apparently free discharge. On the one hand, it is almost invariably related to strongly repressed sadistic elements, and on the other, the discharge itself is more apparent than actual; when we come to investigate more closely, we shall find that the emotional charge is far from depleted. Patients of the latter type usually present hysterical characteristics, whilst the type first described have a more obsessional disposition.

When maladjusted cases shew some disposition to sidle away from the emotional situation, *we must encourage them to exhaust their feelings on this subject and particularly to give free play to their phantasies about the ultimate outcome.* On the other hand, *when their emotional discharge is excessive, we must, having allowed a legitimate interval, begin to curb this discharge by interpreting its significance as a sadistic reaction-formation.* This must be done as early as possible to clear the ground for interpretation of the punishment-tendencies which become more apparent when the emotional charge has been reduced. Almost simultaneously we shall find ourselves preoccupied with transference-material, most frequently of a negative kind. This is not surprising, because, as we have seen, such patients *commence* analysis with a disposition of mental defences which in the transference-neurosis is seen more clearly during the *second stage* of analysis. So with due caution *we must be prepared to give deep transference-interpretations, making clear as soon as possible the nature of the unconscious hostile impulses.* If we do not take some such course, we are apt to find ourselves going through what appears to be an interminable first stage and to land ourselves ultimately with no alternative but to be satisfied with some degree of intellectualistic conviction on the patient's part, in other words with an incomplete and unsatisfactory analysis.

Now with regard to the use of ' active ' measures: maladjusted cases would appear to provide suitable opportunities for investigation of active methods. For my own part, I think that they do offer scope

in this direction, but only under certain conditions. It may be necessary on isolated occasions to take some early opportunity of regulating the external situation, but, on the other hand, we have to remember that *their manipulation of this external situation is really a substitute for a symptom* and cannot be immediately attacked with the same success as external displacements from a ' transference-neurosis '. There are, in my opinion, three pre-requisites for successful interference: (1) free interpretation of punishment-tendencies once these become more obvious as the result of adequate emotional discharge; (2) the appearance of mild neurotic symptoms or the exacerbation of existing minor symptom-formations (or of existing psychosexual inhibitions); (3) vigorous transference-interpretation directed mainly to negative manifestations. When these objects have been satisfactorily attained, and a suitable interval for ' working through ' has been allowed, we may aim at ' frustration ' exercises, proceeding on the system of gradual approach indicated in the last lecture.

You may be curious to know why I have spent so much time on these cases of maladjustment. As far as numbers go, they cannot claim to be ' exceptional ', and the patients themselves certainly claim to be normal individuals. Nevertheless, my own view is that, next to psychotic or borderline cases, they are the most difficult subjects for analytic treatment. In fact, it is no uncommon thing to find that, after a certain amount of effective analysis, some of them shew quite distinct psychotic mechanisms. *This is one of the reasons why we should not come too hastily to the conclusion that they are fit subjects for ' active ' therapy.* To mention only a few instances: some of the types described as having very strong emotional reactions may sooner or later uncover mechanisms of a distinctly paranoidal type. We find that there have all along been hidden systems almost bordering on the delusional, e.g. systems of reference, spying manias. Again, should a seemingly positive transference be established we must examine this with the utmost care; it may quite well cover an eroto-maniac mechanism. Above all, a rapidly established transference-situation must be regarded with suspicion. On the other hand, cases which at first sight appear to be mainly obsessional in type must be carefully watched when signs of depression appear. One should not be surprised to note the appearance of suicidal phantasies which may on isolated occasions be so strongly charged as to give rise to some anxiety. As a rule there is no immediate danger that these phantasies will be carried into action; nevertheless it is advisable to direct our attention more

carefully for the time being to the investigation of the repressed sadism, combining this with a judicious interpretation of the transference-significance of such phases. When these transference-phantasies become more highly charged than usual, it is easy to see that they have an early anal-sadistic background and are vehemently repudiated by the super-ego. The situation is similar to that social situation where an approaching marriage leads to suicidal attempts.

At this point we must begin to consider those modifications of analytic technique which, as we hinted in the last lecture, are more appropriate to the *treatment of psychotic types*. We then suggested that there might be occasions when it was advisable to play the part of the super-ego in a positive sense, viz. by means of relaxations of technique, the use of advice, encouragement or other direct employment of transference-authority to influence decisions and immediate conduct. But first of all let me complete what has to be said about maladjusted cases, which shew during analysis some tendency to psychotic reaction. To begin with, how are we to size up this reaction? when have we to take it seriously? Our instinctive analytic feeling will often guide us in this matter, but should we be unable to arrive at a decision by this rapid method, we must have recourse to one of these 'surveys' to which we have previously referred on one or two occasions. After all, we ought to have sufficient material on which to base a considered judgement. Starting with the question of fixation, we may review what facts have transpired as to the patient's psychosexual activities. If gratification has taken place, we know what type this has been, whether mainly genital or pregenital; if pregenital, what components have been accentuated. We can check these deductions from our knowledge of the patient's habits, actions and characteristics. If no gratification has taken place, we must fall back on observation of habits together with a survey of attitude to external objects. Then we have the 'miniature' symptom-picture which we can value in accordance with the preponderance of anxiety-formations, minor phobias, compulsive characteristic or depressed states. We shall have been particularly watchful for changes of mood and for hypochondriacal preoccupations. Finally, we have the analytical material itself: the dream-life and the nature of whatever transference manifestations have been exhibited. On these data we must depend for our ultimate conclusion: they enable us to control our instinctive judgement of the seriousness of the crisis. As I have suggested, in a majority of instances we shall be able to carry the

analysis through, but in some cases we must pay special attention to the particular type of defensive mechanism in the psychotic reaction. Having dealt with the crisis on these lines, we may again settle down to a prolonged process of working through.

This variation of extreme passivity, to allow of working through, together with careful but purposive interference at critical moments, is a good training for the handling of borderline cases. Now the word ' borderline ' covers a multitude of suspicions and generally indicates that some regressional and restitutive characteristics have been observed which are reminiscent of the psychoses. But of course, as we know, there are few psychoses which do not present mixed or transitional features, so that the borderline diagnosis is simply a shade more uncertain than the diagnosis of larger psychotic groups. To avoid dissipating our energies on a scrappy review of different psychotic types, I propose to limit our consideration to the *milder depressive states*.

The analytic investigation of such conditions has not yet reached the stage when hard and fast guiding rules can be laid down. Hence it is true to say that our therapeutic endeavours are at the same time scientific investigations and that *our attitude is on the whole opportunist.* On the other hand, much more accurate information has been placed at our disposal in recent years through the pioneer work of Freud and Abraham. So that, whilst we are well advised to maintain the opportunist attitude, we must familiarize ourselves with the characteristic mechanisms which have already been established, and in accordance with which we may, in part at any rate, shape our policy. I take it we are all familiar with the processes of ego-ideal formation and the freeing of aggressive components which follow on the conversion through introjection of object-libido into narcissistic libido. The next point to bear in mind is the process of introjection of the object and identification with the ego which occurs in melancholia. This identification comes about the more easily that in such cases the original object-choice is of the narcissistic type. We are then in a position to see that where the freeing of aggressive components is specifically increased, as in the super-ego formation of depressed types, the characteristic appearances are explained by the turning of the super-ego on the ego which has taken the place of the object. If we inquire into the nature of this specific increase, we find that constitutionally these patients have a strongly reinforced oral-erotic interest, which tends to lead to individual fixation in the ambivalent

stage of oral development, that of incorporation and destruction (the second oral stage described by Abraham). Again, we find that when regression takes place it proceeds rapidly back through the second anal-sadistic stage of retention and mastery to the first anal-sadistic stage of expulsion and destruction. We can see then that the introjection of the object is a sort of restitutive attempt to preserve it, but on a narcissistic basis; the ego is identified with it. The restitution is, however, a source of danger, because it enables the super-ego to attack, a process which, if driven too far, ends in the destruction of the self and not of the object. We must therefore be on the outlook for extreme ambivalence in these states. Further, we know that such persons have experienced traumatic disappointment of their love-strivings from the time of their earliest exhibition, and that, as a rule, they have been unable to compensate for this by gratification in respect to the parent of the opposite sex. Moreover, their first disappointment having occurred before the Œdipus phase could be overcome, and at a time when the attitude to the father is extremely ambivalent, they remain fixed at the oral cannibalistic stage of ambivalence. Given then a later disappointment or depreciation of love situations, the way to regression is open. Whilst the introjective process involves both parental images, the main part relates to the mother-image, and the castration imagery which plays so prominent a part in the analysis of such cases relates mainly to castration by the mother.

These are but a few of the essential facts, which can be easily confirmed by the analytic observation of depressed cases. For example, the attitude of extreme ambivalence to objects is soon apparent, and the heightened significance of oral images is quite unmistakable. This provides one of the best opportunities of learning to decide on a point which is so often a difficulty in ordinary analysis, viz. whether a preoccupation with oral images is a defensive displacement or is the result of fixation. In depressed cases oral phantasies are evidenced in all directions; they are accompanied by extremely aggressive images and an attitude of bitter and implacable disappointment. Moreover, they are extremely refractory to interpretative handling, whereas in the ordinary displacement we are usually able to obtain some movement, however temporary, and some lighting up of genital images. As to the transference, it is easy to see that this is on a narcissistic basis, and that for some time our hold of the case will depend on this being undisturbed. On the other hand, we are faced with the difficulty that their object-relations prior to disappointment

were of an extremely unsatisfactory kind, owing to the ambivalent type of love-relation implied. So that as a case progresses we are inevitably faced with a repetition of these object-relations. We find ourselves identified mainly with the mother-images, and as these relations involve the expression of sadistic attitudes, it is reasonable to expect that increase in negative transference will be associated with crises in the treatment. Put in simple terms, as the transference-phantasies increase we shall be on the outlook for increased depression on the patient's part or for increase in self-destructive images and in some instances abortive attempts at self-injury. In an ordinary analysis it is taken as a rough guiding rule that positive transferences may for a time be left to themselves, but that negative transferences never can. And it is, of course, true that in many cases we can never really assess the significance of the positive transferences until the negative group have been ventilated. In the cases we are describing, the term ' narcissistic ' transferences might be substituted for ' positive ' transferences, whilst the ' negative ' transferences contain vestiges of an archaic object-relationship. But they are explosive remainders. We are really in a constant dilemma (provided, of course, we are making any progress at all) : if we interfere too much, that is to say, if we do not live up to the narcissistic relationship, we immediately heighten the ambivalent reactions of the patient ; if we interfere too little, we are really abandoning him to his own defences against transference-phantasy : and these may take an unpleasant form. Again, if we interfere too much, we are ignoring an imperative necessity, viz. to allow patients to work through their traumatic and injury phantasies. So our problem is really to allow for all these varying necessities. How is this balance to be effectively maintained ?

Evidently *the first requirement is simply to maintain the analytic situation on the narcissistic level, to allow patients ample scope for elaboration and reiteration of their ideas, which will be found to stick closely to certain stereotyped patterns and situations.* But at the very beginning we must study the material very closely to see if we can discover *danger signals,* either in the form of recurrent types of dream or recurrent images. One suicidal patient, for example, always before crises in the analysis found her mind filled with certain snatches of music, which at a later stage she, of her own accord, christened ' Death-music '. It was an infallible indication. Again, day-dreams and phantasies concerning pale-faced individuals who conversed or argued with red-faced people were an indication that she would soon be toying

with the idea of throwing herself over Battersea Bridge. I do not, of course, mean that during these passive periods we say nothing. To begin with, we certainly let them run on undisturbed, although we must be immediately ready with help should they find difficulty in maintaining their lines of thought. Note, however, whether they repudiate this assistance, and be guided by their reactions as to the optimum amount to give. Gradually we turn these helping occasions to advantage. Our help becomes a very little more explanatory. And these explanations, although of the most general sort, should be directed towards easing the pressure of sadistic phantasy. We do not require to illustrate our explanations by reference to their own case. They may not be ready for personal illustration. We can always put our tentative illustrations in an indirect way, e.g. a hypothetical small boy or girl. We are preparing all the time for future contingencies. But sooner or later we find ourselves compelled to take a more personal line of approach. We may see that some of their preoccupations have a more direct relation towards ourselves. Now, as I have indicated, we cannot rest content with a simple interpretation of the type we may give transference neurotics. *We must do it in two moves.* We must follow up any phantasy-interpretations *as soon as possible* with some accessory interpretation which lessens the patient's reaction. This usually takes the form of ventilating the method of instinct-modification by which sadistic impulses are turned in on the self and serve the purposes of punishment. If no death-music is then reported we may with some relief take refuge once more in the narcissistic analytical relationship.

The next problem is whether we can adapt the processes of free association to the urgent necessities of these patients, e.g. *whether we can temporarily head them off a line of thought which threatens to open up an old sore before they are capable of handling the associated affect more successfully.* As a matter of fact, it is very obvious that, like all other patients, the depressed case does a good deal of heading off on his own account. But as a rule he differs in his conscious reaction to this defence: he feels no guilt about the suppression, saying simply, ' I can't stand this idea at all '. The unconscious mechanisms are, in comparison with the defensive manœuvres of ordinary cases, very patent and crude. For example, we find that their minds are much preoccupied with screen-memories, and that when a difficulty arises in other directions they can take refuge in these images. They will say ' But I must get back to that memory ', or ' to that court-yard ',

or 'to that pig image.' Again, the sequence of thought may be interrupted by a series of pictorial images of almost hallucinatory strength; the switch is so abrupt that there can be no doubt of its defensive purpose. Or, again, they become rather abstracted and are found to be quietly preoccupied with some images and patterns which they are tracing on the ceiling or cornices or carpets of the analyst's room. My own impression is that on certain occasions we may legitimately initiate the same process; this can be quite easily effected without drawing the patient's attention to the manœuvre. *It is not justifiable unless we feel that his absorption limit has been reached.* The simplest and most effective way of heading is to bring up almost casually some reference to points of view which will tend to alleviate guilt-processes. With certain elderly people I would not hesitate, if the occasion demanded, to give them a sort of temporary dispensation from the strict association rule. I am illustrating here one aspect of the problem of relaxation of technique, and must be content with simple reference to other aspects, e.g. assistance in arriving at decisions or a more definite humouring of the patient's whim, provided all the time we regulate this process by the actual needs of the case. It would be tempting to go on to consider the actual details of super-ego analysis in such cases, but this is beyond the scope of this lecture, which is concerned mainly with the formulation of technical policies. It is permissible to note, however, that the success of analyses of depressed cases depends on unravelling the interplay of introjections and identifications as between the super-ego and the ego. It is not difficult to see direct illustration of single facets of this relationship. A patient says in rapid succession and rather convulsively, 'You are a beast . . . you beast'. The first is a reproach of me as an object, disguising at the same time certain primitive phantasies; the second part is a self-reproach for reproaching me and at the same time an identification.

Incidentally, *extreme* relaxation of technique may be necessary in elderly cases, when the individual has embarked on a permanent regression which it is our aim to modify or arrest. Our hopes are often much less sanguine than those entertained in more severe types of depression of younger subjects. Generally speaking, we combine a much more friendly and explanatory attitude with a process which has some resemblances to the technique of 'forced phantasy', but, of course, with a different aim. Briefly we take advantage of the scrappy information gleaned in earlier sessions to suggest topics of conversation,

always with some idea of the effect we intend to produce by this selection. If we cannot do this and the analysis lags, we deliberately stimulate a narcissistic element of gratification in the analysis, encouraging them to choose their own subjects, as if saying, ' Well, what would you like to talk about to-day ? '

But it is time to return to the main concern of these lectures—the technique of psycho-analysis as applicable to the transference-neuroses—and to inquire whether our experience of exceptional cases can be turned to advantage in the handling of these neuroses. Generally speaking, treatment of difficult and borderline cases drives home the necessity of combining *two* attitudes in the ordinary analysis. *The first is one of extreme passivity and the second of judicious but pointed and purposive interpretation.* We see how in psychotic types for quite prolonged intervals our function is simply *to maintain the analytic situation.* Whatever degree of transference exists has a narcissistic basis, so that at times we get dispensations from the patient for our own existence provided we do not interrupt him. A word here and there may be all that is necessary; sometimes complete and absolute passivity is essential. We have seen how, left to himself, the processes of elaboration, amplification, expanding over-determined presentations, filling up amnesic gaps, go on constantly and increasingly up to a point when difficulties accumulate. The patient has worked through and around certain images until some detachment of cathexis occurs. But even relatively slight loosening of libido may provoke violent reactions, which tend either to evade the transference or to stampede through it into external attitudes and actions. *When this occurs our concern is not so much with the repressed material as with the defensive forces, above all with the instigators of repression, i.e. the super-ego attitudes, with the type of punishment involved, and with the aggressive or sadistic impulses manifested.* To take one instance, if in a borderline case we felt that the violent reaction was related to homosexual phantasies, it would be bad policy for the moment to make interpretation of homosexual phantasies, but good policy to provide for ventilation of aggressive attitudes and of the mechanism of inverting sadism. A third point is abundantly clear in the handling of such cases, viz. *one must be chary of premature interpretations.* We see the patient's attention drawn magnetically towards certain traumatic phantasies, circling round and round, only to dart off violently at a tangent when contact becomes too close, like a moth from a candle. So that much of our interpretation is really explanatory, e.g. smoothing the path for

tabulation of sexual theories, ventilating punishment-systems in a way which is not too unpalatable, and on the whole following the patient's own plans of working round the subject. Otherwise a direct interpretation of, for example, a homosexual phantasy may simply lead to an explosive reaction quite beyond our control.

Again, we are able from analytic observation of borderline cases to formulate a rough guiding rule by which we can *regulate the extent of positive or advisory interferences*. As we have seen, we may explain more, and we may also play an advisory *rôle* in respect to some external decisions on the good ground that the patient is unable to arrive at a sound reality decision himself. We may relax our attitude of analytic detachment in many minor ways ; but in the treatment of a psychotic we always have good reasons for doing so. The nature of the transference, the seriousness of the patient's condition and his incapacity to handle external relations enable us to play these positive parts without stirring up any of our own defences against counter-transference. We may therefore lay down as a safe standard that when in the case of transference-neuroses we feel called upon to follow a similar, if less obvious, policy, it must always be to effect some immediate purpose and never to reflect some counter-transference mood of our own. We learn from the psychoses more of the grim urgencies of mental conflict and the compelling force of instinctual drives, and this understanding is an excellent antidote to any tendency to regard analytic technique as a discipline. After all, the technique was evolved to meet the case and, if we are satisfied that there have been no gaps in our method, we may modify it in whatever way seems appropriate, provided we do not abandon the fundamental approach to repressed content or neglect our established findings as to the nature of conflict. But when we do utilize modifications we must be quite certain that this has no relation to a revenge-impulse stimulated by the fact that the case has not evolved itself to meet the technique.

It would be merely a repetition of what we have already said, concerning the passivity to be employed in psychotic cases, if we added that in the handling of such cases we are never hampered by worries as to the duration of treatment. But it is legitimate to add that we can modify also our sometimes too exacting therapeutic requirements. In these difficult cases we are glad to observe as the ultimate result of our labours the attainment of a stage of development with which we should be distinctly disappointed in the case of a neurotic person. We are glad even to have called a halt to the repressions, to have

reduced a delusional system to a series of obsessional ideas. We are content to leave them with hysterical phobias or conversion-symptoms of a not too crippling order. We may sometimes welcome the appearance of sublimatory activities which ultimately deplete the never strongly charged analytic relationship. We may welcome signs of transference which in neurotic cases we should analyze tirelessly. The moral which we may carry back to the usual analytic practice is not that we should ever water down our ideal of conscious adaptation, but that we should regulate our analytical dosage with an eye to the circumstances to which from time to time the patient must adapt.

And this brings me once more to the analyst's *attitude* to analysis. It has often been said by analysts of considerable experience that they are even yet in constant states of uncertainty as to standardized technique. They feel that, in spite of earlier conclusions, they do not quite know in any one case just how passive they must remain, how much they must say, or how little, exactly what routine should be applied in any one crisis. Now, if we are entitled to assume that an analyst's clinical material has been sufficiently varied and that his subjective difficulties are well in hand, I could imagine no more ideal attitude than is represented by this uncertainty. After all, lectures on technique are concerned only with fundamental principles. When a technical problem is brought forward for discussion it is notoriously difficult to supply a satisfactory answer without hedging it by qualifications. A satisfactory reply as to a general guiding principle may be given, but it must in fairness be immediately qualified by knowledge of the existing circumstances. And knowledge of existing circumstances really implies a summary of the whole previous analysis. I imagine this is really the reason why the people who are most diffident about writing treatises on analytic technique are those who have been in a position to discuss technical difficulties.

But to come back to the question of attitude, I feel sure that absence of dogmatic certitude as to procedure, *provided it is unaccompanied by anxiety,* is the ideal reaction. It is, after all, never a question of how passive or how interpretative we should be in psychoanalytic practice as a whole, but how passive we should be in any one case. Our own uncertainty is often merely the reflection of a current conflict in the patient's analysis. We know that in the processes of adaptation he has developed an ego-system to regulate his instinctual life in accordance with reality as it appears at different times. The more primitive the view of reality, the more archaic the ego system,

so that our analytic attitude is bound to fluctuate constantly in accordance with the exigencies of this id-ego relationship. The attitude of passivity is not only an essential part of the technique whereby we reach repressed material: it is a concession to the necessities of instinctual life. The terms ' resistance of the Id ' and ' working through ' here come into their own. On the other hand, our interpretative interference is not only an essential part of the technique by which we reach unconscious attitudes to repressed material: it is a recognition of the ego's attitude to danger which we seek to modify. Super-ego analysis then comes to its own, as a recognition of earlier danger-situations which have preserved their keenness in spite of having no real touch or only very slender contact with existing dangers. ' Activity ' in the Ferenczi sense is merely a device for throwing into relief one or other of these urgencies, viz. id-drives or archaic danger-situations sensed by a primitive ego. It is an accentuation of the frustration element deliberately undertaken, but is in no other sense an addition to or modification of analytic technique. The results of frustration have to be analyzed in the ordinary way. For this reason I do not favour the description of his technique as ' analysis from below '. At the best it is a cleverly planted blow or stimulus, the results of which are then analyzed from above. It is for the analyst to decide what balance of advantage will be obtained by coming out of his armchair-neutrality to deliver this stimulus, to settle how powerful it must be, and how often it should be applied. Having come to this decision and administered his stimulus, he continues analysis from above.

I may perhaps summarize here my own views on the problem of *activity*, since the stage of authoritative direction on this point has by no means been reached. If we are certain of the analytic situation which will arise after instituting frustration-exercises or giving recommendations calculated to head off ' flights from analysis ', and provided we do not jeopardize the analysis, there is no logical reason why these activities should not be pursued as far as any empirical advantage is to be obtained, and Ferenczi, with his usual courage and ingenuity, has shewn us how we can follow the procedure more or less systematically. The method suggested by Freud seems to me, however, to offer the best system of control. Freud does not favour being influenced by considerations of speed, i.e. the desire to shorten analysis, but he does favour those privations and recommendations which are instituted in direct relationship to the symptom-picture and the transference-

charge. Those who wish to go beyond this amount of interference must submit themselves to more rigid control. They must satisfy themselves that the ordinary methods of analysis have been fully exhausted, that they are not influenced by any subjective reactions of impatience. Assuming that these conditions are fulfilled, I would then favour an approach to privation-tests through interpretation of defensive attitudes, calling attention to the persistence (in spite of explanation) of exaggerated flight-reactions or reaction-formations; analytic focussing of attention is a good preliminary to actual recommendations.

Working back, then, is there anything further to be said about exhausting the ordinary methods of analysis? In general, I have tried to emphasize that these methods have a twofold direction. We seek to uncover repressed material and to give room for its sufficient expansion and elaboration when uncovered; but we also aim very definitely at discovering the reasons why it was repressed, what exactly was the point of view of the primitive ego, why it scented danger, what theories it had woven, what conclusions it had arrived at, and by what manipulations of the infantile child-parent relationship it succeeded in getting the upper hand of its primitive instinctual urges. *If anything, we have in the past been content with the uncovering of primitive urges, paying perhaps too little attention to the process of gradual modification of these urges as the result of changing ego-attitudes.* Now the stage when all this can be most satisfactorily worked out is the second stage of analysis, that of the ' transference-neurosis ', although we have seen that some effective work on the same lines may be done in the opening phase and that in the terminal stages transference-interpretation continues coupled with analysis of regressional movements. *The ideal analysis of a transference-neurosis is one where there is a pendulum-swing between passivity and interpretation, between analysis of the repressed and of the repressing forces, between libido-analysis and ego-analysis.* When for some reason or another the excursion of the pendulum is interfered with, we must redress the balance, and this is done literally by raking through the whole analytic situation to find further fuel for the transference. Every situation, action or idea provides combustible material, but we choose the material in accordance with the requirements of the moment: if libido-analysis is deficient, we rake in more transference-phantasies; if ego-reactions are too strong, we extend them before the patient as they are reflected in transference-attitudes.

Going still further back, *we may regard the opening phase as a*

mobilizing phase on both sides of the analytic situation. We prepare the patient for effective analysis by clearing the ground of obstacles; we mobilize energy, knowing all the time that it will inevitably collect in the transference-reservoir, and our ideal attitude is to regulate this flow, so that it neither trickles nor pours into that reservoir. But at the same time we are mobilizing our own impressions and are collecting as many observations as possible as to the nature of the case. We should in fact, towards the end of the opening phase, have a fairly reliable forecast of the crises we may have to face later on, and if we keep this in mind during the transference-neurosis, we are not likely to be stampeded into sudden changes of policy, or to be faced with disruption of the analytic situation.

But the best cure for stampeding is, after all is said, our conviction as to the accuracy of psycho-analytic findings, and the only factors likely to subvert that conviction are subjective factors. So we come back once more to the view expressed in the opening lecture, that the difficulties of analytic technique are twofold: those relating to the patient and those relating to the analyst himself; that of these the difficulties incident to the analyst are the more important. Our greatest safeguard in all situations of difficulty is a state of freedom from unconscious bias which can only be obtained by analysis of the analyst.

International Psycho-Analytical Library

Edited by ERNEST JONES

No. 1. **Addresses on Psycho-Analysis.** By J. J. PUTNAM. With a Preface by SIGM. FREUD. 12s. 6d.

No. 2. **Psycho-Analysis and the War Neuroses.** By S. FERENCZI (Budapest), KARL ABRAHAM (Berlin), ERNST SIMMEL (Berlin) and ERNEST JONES (London). Introduction by SIGM. FREUD (Vienna). 5s.

No. 3. **The Psycho-Analytic Study of the Family.** By J. C. FLÜGEL. Second Edition. 10s. 6d.

No. 4. **Beyond the Pleasure Principle.** By SIGM. FREUD. Authorised Translation from the second German Edition by C. J. M. HUBBACK. 6s.

No. 5. **Essays in Applied Psycho-Analysis.** By ERNEST JONES. 18s.

No. 6. **Group Psychology and the Analysis of the Ego.** By SIGM. FREUD. Authorised Translation from the German by JAMES STRACHEY. 7s. 6d.

Nos. 7–10. **Collected Papers of Sigmund Freud.** *Four guineas the set.*

Vol. I. **Early Papers.** History of Psycho-Analytical Movement. 21s.
II. **Clinical Papers.** Papers on Technique. 21s.
III. **Case Histories.** 30s.
IV. **Papers on Metapsychology and Applied Psycho-Analysis.** 21s.

No. 11. **Further Contributions to the Theory and Technique of Psycho-Analysis.** By SANDOR FERENCZI. 28s.

No. 12. **The Ego and the Id.** By SIGM. FREUD. 6s.

No. 13. **Selected Papers on Psycho-Analysis.** By KARL ABRAHAM. 30s.

No. 14. **Index Psychoanalyticus 1893–1926.** By JOHN RICKMAN. 18s.

No. 15. **The Future of an Illusion.** By SIGM. FREUD. 6s.

Published for the Institute of Psycho-Analysis

BY

THE HOGARTH PRESS

52, TAVISTOCK SQUARE

W.C. 1